No. _____ Supreme Court, U.S.
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In The Supreme Court Of The United States

OCTOBER TERM, 1993

CRAWFORD B. SMITH, JR. and
JEANNIE SMITH,

Petitioner

v.

JEFFERSON PILOT LIFE
INSURANCE COMPANY,

Respondents.

ON PETITION FOR WRIT OF CERTIORARI
FROM THE UNITED STATES COURT OF
APPEALS FOR THE ELEVENTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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113 pp

I. QUESTIONS PRESENTED FOR REVIEW

1. WHETHER ERISA'S "SAVING CLAUSE", 29 U.S.C. §1144(b)(2)(A), PREVENTS THE PREEMPTION OF PETITIONERS' STATE LAW CAUSES OF ACTION GROUNDED UPON RESPONDENT'S BREACH OF AN INSURER'S NOTICE DUTIES ARISING UNDER GEORGIA'S WRITTEN NOTICE OF CANCELLATION STATUTE, O.C.G.A. §33-24-44(d)?

2. WHETHER 29 CFR §2510.3-1(e), PROVIDING THAT ERISA PLANS DO NOT INCLUDE SALES BY AN EMPLOYER TO ITS EMPLOYEES OF ARTICLES OF THE KIND WHICH THE EMPLOYER OFFERS FOR SALE IN THE REGULAR COURSE OF BUSINESS, OPERATES TO EXCLUDE FROM ERISA'S SCOPE THE GROUP HEALTH INSURANCE PRODUCT WHICH RESPONDENT PROVIDED TO PETITIONER CRAWFORD SMITH?

II. TABLE OF CONTENTS

I. QUESTIONS PRESENTED FOR REVIEW i

II. TABLE OF CONTENTS ii

III. TABLE OF AUTHORITIES v

IV. OPINIONS BELOW 1

V. JURISDICTION 1

VI. STATUTES AND REGULATIONS INVOLVED 2

VII. STATEMENT OF THE CASE 3

(i) COURSE OF PROCEEDINGS AND DISPOSITION BELOW 3

(ii) SUMMARY OF FACTS 8

VIII. ARGUMENT/REASONS FOR GRANTING WRIT OF CERTIORARI 20

A. ERISA'S SAVING CLAUSE OPERATES TO PREVENT THE PREEMPTION OF PETITIONERS' STATE LAW CAUSES OF ACTION GROUNDED UPON RESPONDENT'S VIOLATION OF GEORGIA'S WRITTEN NOTICE OF CANCELLATION STATUTE, O.C.G.A. §33-24-44(d) 21

(1) THE GEORGIA NOTICE OF CANCELLATION STATUTE IS CONCERNED WITH RISK-SPREADING 24

(2) GEORGIA'S NOTICE OF CANCELLATION STATUTE IS DIRECTED AT AN INTEGRAL PART OF THE POLICY RELATIONSHIP BETWEEN THE INSURER AND THE INSURED 34

(3) IF GEORGIA'S NOTICE OF CANCELLATION STATUTE IS SAVED FROM ERISA PREEMPTION, THEN ALL CAUSES OF ACTION ARISING UNDER THAT STATUTE ARE ALSO SAVED..... 37

B. THE DEPARTMENT OF LABOR'S REGULATION, 29 CFR §2510.3-1(e) REMOVES RESPONDENT'S HEALTH INSURANCE PLAN OR PROGRAM AT ISSUE FROM ERISA'S SCOPE 48

IX. CONCLUSION 56

APPENDIX (commencing a new sequence of page numbers) 58

OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT DATED FEBRUARY 2, 1994, OFFICIALLY REPORTED AS SMITH v. JEFFERSON PILOT LIFE INSURANCE COMPANY, 14 F.3D 562 (1994) 1

JUDGMENT OF UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT ENTERED FEBRUARY 2, 1994.. 33

ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT DATED (DATE STAMPED) SEPTEMBER 28, 1993 GRANTING RESPONDENT'S PETITION TO APPEAL PURSUANT TO 28 U.S.C. §1292(b).... 35

ORDER OF THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA, COLUMBUS DIVISION DATED AUGUST 19, 1992 ADDING THE LANGUAGE REQUIRED BY 28 U.S.C. §1292(b), SO AS TO PERMIT RESPONDENT TO SEEK AN IMMEDIATE APPEAL 37

MEMORANDUM AND ORDER BY THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA, COLUMBUS DIVISION ON MOTIONS FOR SUMMARY JUDGMENT, DATED APRIL 20, 1992 38

STATUTES AND REGULATIONS INVOLVED:

29 U.S.C. §1132(a) 41

29 U.S.C. §1144(a) 43

29 U.S.C. §1144(b) 43

O.C.G.A. §33-24-44 44

29 CFR §2510.3-1(e) 46

III. TABLE OF AUTHORITIES

Cases

Eaton v. Delta Airlines, Inc., No. C87-748(C) WD - Lexis No. 15986, a decision of the United States District Court for the Western District of Washington 50, 54

FMC Corp. v. Holliday, 498 U.S. 52, 111 S. Ct. 403, 112 L.Ed.2d 356 (1990) 24, 25 26, 41, 42, 43 44, 45, 46, 47

Gahn v. Allstate Life Insurance Co., 926 F.2d 1449 (5th Cir. 1991) 32, 36

General American Insurance Company v. Samples, 167 Ga. App. 622, 305 S.E.2d 51 (1983) 26, 36

Graves v. Blue Cross of California, 688 F. Supp. 1404 (N.D. Cal. 1988)..... 38

Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 99 S. Ct. 1067, 59 L.Ed.2d 261 (1979) 29

Hansen v. Continental Ins. Co., 940 F.2d 971 (5th Cir. 1991) 53

John Hancock Mutual Life Insurance Co. v. Harris Trust & Savings Bank, ____ U.S. _____, 114 S. Ct. 517, ____ L.Ed.2d ____ (1993) 30

Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 105 S. Ct. 2380, 85 L.Ed.2d 728 (1985) 22, 23 24, 25, 28, 31

Pilot Life Insurance Company v. Dedeaux, 481 U.S. 41, 107 S. Ct. 1549, 95 L.Ed.2d 39 (1987)..... 24, 26

Smith v. Jefferson-Pilot Life Ins. Co., 14 F.3d 562 (11th Cir. 1994) 1, 8 22, 24, 28, 35 37, 38, 39, 40

Ticor Title Ins. Co. v. Federal Trade Commission, 998 F.2d 1129 (3rd Cir. 1993) 32, 33 35

Tomczyk v. Blue Cross and Blue Shield United of Wisconsin, 951 F.2d 771 (7th Cir. 1991) 39, 40

Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 102 S. Ct. 3002, 73 L.Ed.2d 647 (1982)..... 23, 26 28, 29, 30 32, 35

WMH, Inc. v. Thomas, 195 Ga. App. 61, 392 S.E.2d 539 (1990) and 260 Ga. 654, 398 S.E.2d 196 (1990) 27

Federal Statutes

"Employee Retirement Income Security Act" (ERISA) ..... Passim

"McCarran-Ferguson Act" 23, 25 28, 29, 32 39, 40

28 USC §1332 4

28 USC §1441 4

29 USC §1132 ..... 4, 44
47, 48

29 USC §1144(a) 5

29 USC §1144(b)(2)(A) (ERISA "saving clause"). ..... i, 6
21, 23, 24
30, 32, 33
37, 38, 41
43, 45, 47
48

29 USC §1144(b)(2)(B) (ERISA "deemer clause") 24, 26
42, 45, 47
48

Federal Regulations

29 CFR §2510.3-1(e) ..... i, 6
48, 49, 50
52, 53, 54
55

Georgia Statutes

O.C.G.A. §33-24-44(d) ..... i, 4
5, 7, 21
22, 26, 27

Treatises

Couch on Insurance 2d (Rev. ed. 1984)... 24

Legal Encyclopedias

44 Corpus Juris Secundum, Insurance.... 29

Dictionaries

Webster's New Collegiate Dictionary (1979) 54

IV. OPINIONS BELOW

The opinion of the United States District Court for the Middle District of Georgia, below, granting partial summary judgment to Petitioners on the ERISA issues, was not reported and is set out in full in the Appendix. The opinion of the United States Court of Appeals for the Eleventh Circuit, below, reversing the District Court, is reported at 14 F.3d 562 (1994) and is also set out in full in the Appendix.

V. JURISDICTION

The judgment of the United States Court of Appeals for the Eleventh Circuit below (set forth in full in the Appendix) was entered on February 2, 1994, the same day as that Court's opinion reported at 14 F.3d 562 (1994). The jurisdiction of this Court is invoked under 28 U.S.C. §1254(1).

VI. STATUTES AND REGULATIONS INVOLVED

The relevant statutory provisions are the following provisions of the Employee Retirement Income Security Act (ERISA): 29 U.S.C. §1132 (the ERISA "Civil Enforcement" scheme); 29 U.S.C. §1144(a) (the ERISA preemption clause); 29 U.S.C. §1144(b)(2)(A) (the ERISA "saving clause"); 29 U.S.C. §1144(b)(2)(B) (the ERISA "deemer clause"), as well as Official Code of Georgia Annotated §33-24-44(a) and (d) (Georgia's "written notice of cancellation" statute).

The relevant regulatory provision is the Department of Labor's Regulation, 29 C.F.R. §2510.3-1(e).

All of the statutory and regulatory provisions just cited are set forth in full in the Appendix.

VII. STATEMENT OF THE CASE

(i) COURSE OF PROCEEDINGS AND DISPOSITION BELOW

Crawford B. Smith, Jr. (sometimes hereinafter referred to as "Smith") and his wife, Jeannie Smith, Petitioners herein (sometimes hereinafter referred to as Plaintiffs), filed suit in August of 1987 in the Superior Court of Muscogee County, Georgia against Respondent, Jefferson-Pilot Life Insurance Company, formerly Pilot Life Insurance Company (sometimes hereinafter referred to as "Defendant", "Jefferson-Pilot", or "employer") seeking money damages for the tortious termination of the major medical health coverage of Smith's wife, Plaintiff Jeannie Smith, which Jefferson-Pilot had made available to Smith as its employee, and which had been wholly paid for by Smith. Jefferson-Pilot promptly removed the action to the United States District

Court for the Middle District of Georgia, Columbus Division, under the provisions of 28 U.S.C. §1441, alleging that federal jurisdiction existed "pursuant to 28 U.S.C. §§1332, 1441 and 1132 [sic]", apparently actually intending to refer to 29 U.S.C. §1132.

The Smiths conceded that Respondent's removal of the case to the United States District Court was proper. The provisions of 29 U.S.C. §1132(e) and 28 U.S.C. §§1332 and 1441 formed the basis for federal jurisdiction in the federal court of first instance.

The Smiths' state law causes of action are predicated on Jefferson-Pilot's violation (contended by the Smiths to have been intentional) of the provisions of O.C.G.A. §33-24-44(d). That Georgia statute required Jefferson-Pilot to have rendered at least ten days advance written notice of the termination of coverage. Jefferson-Pilot

defended the Smiths' suit on the ground, inter alia, that the medical coverage for Mrs. Smith had been provided by Jefferson-Pilot through a major medical benefit plan governed by the Employee Retirement Income Security Act ("ERISA"), and that the Plaintiffs' claim under O.C.G.A. §33-24-44(d) was preempted by ERISA, 29 U.S.C. §1144(a). Jefferson-Pilot, Smith's employer, also contended that O.C.G.A. §33-24-44(d) did not apply.

Considerable paper discovery ensued, including numerous interrogatories, requests for production, and some eleven sets of requests for admission propounded by Plaintiffs to Jefferson-Pilot. Only one deposition was taken, that of Smith himself.

In November, 1990, Jefferson-Pilot filed a motion for summary judgment. In December 1990, the Plaintiffs filed their motion for partial summary judgment contending, inter alia, that their state law

causes of action were not preempted by ERISA because of the operation of ERISA's "saving clause" for state laws which regulate insurance, 29 U.S.C. §1144(b)(2)(A). The Smiths also contended that Jefferson-Pilot's sale to Smith of health insurance coverage was not an ERISA "plan" by virtue of regulations promulgated by the Secretary of Labor, including, in particular, 29 CFR §2510.3-1(e).

The United States District Court ultimately decided the issues raised by the parties' respective motions by a memorandum and order dated April 20, 1992. The District Court determined: (1), that the group health insurance policy benefits purchased by Plaintiff Crawford Smith from Defendant to provide dependents' coverage "is not a 'Plan' covered by the Employee Retirement Income Security Act (ERISA)"; and, (2), that if the insurance coverage at issue should be deemed to constitute an

ERISA plan, then the Plaintiffs' causes of action grounded upon Jefferson-Pilot's breach of the duties imposed by O.C.G.A. §33-24-44(d) would "survive ERISA preemption because of the application of ERISA's 'saving clause'."

In August of 1992, the United States District Court amended its memorandum and order of April 20, 1992 to add the statement required by 28 U.S.C. §1292(b) so as to make possible an application for an immediate appeal to the United States Court of Appeals for the Eleventh Circuit (hereinafter usually referred to as "the Eleventh Circuit"). On September 28, 1992, the Eleventh Circuit granted Jefferson-Pilot's petition to be allowed an immediate appeal. After briefing and oral argument, on February 2, 1994 the Eleventh Circuit decided the issues raised on appeal in favor of Jefferson-Pilot and adversely to the Petitioners. The Eleventh Circuit's opinion

of February 2, 1994 is reported at 14 F.3d 562. The judgment of the Court of Appeals was also entered February 2, 1994.

All of the mentioned orders, opinions and judgments are reproduced in the Appendix hereto.

(ii) SUMMARY OF FACTS

On August 1, 1981, Petitioner Crawford Smith signed an employment contract and began his training as a commission agent with Pilot Life Insurance Company, a predecessor of Respondent Jefferson-Pilot Life Insurance Company, to whose obligations Respondent has succeeded. Jefferson-Pilot is a corporation engaged in the business of selling insurance contracts incorporated under the laws of North Carolina and with its home office in Greensboro, North Carolina.

Prior to entering formally into his employment contract, Smith elected to participate in a major medical insurance

program offered by Jefferson-Pilot to its commission agents which included coverage of Smith's dependents. The policy required full payment by Smith as an agent or employee of the cost of the dependents' coverage, with no payment or contribution of any kind by Jefferson-Pilot, the employer. On July 7, 1981, Smith had signed a request styled "Ordinary Representative's Request for Group Insurance" which provided for temporary major medical insurance for himself and his dependents, and later in July, he signed a request styled "Full-Time and Part-Time Agents" which provided permanent coverage for himself and his dependents.

Crawford Smith's "Request for Group Insurance" contained the following authorization for Jefferson-Pilot to deduct a monthly contribution from his compensation account:

> "I authorize [Jefferson-Pilot] to deduct the above monthly amount from my monthly compensation. I agree if there are insufficient funds at that time, I must remit my personal check to [Jefferson-Pilot] to continue my coverage. I understand this check must be received by [Jefferson-Pilot] at it's Home Office not later than 30 days after the due date and if not received, all insurance lapses."

The major medical insurance coverage for Crawford Smith's dependents which he purchased from Jefferson-Pilot pursuant to his insurance agreement with the employer-insurer (wholly paid for by Smith with no contribution by Jefferson-Pilot) was a substantially similar, if not identical, insurance product to that which Jefferson-Pilot offered for sale in the regular course of its business.

The insurance coverage for Smith and his dependents was provided in a group policy which Pilot Life Insurance Company, as an insurer and Smith's employer, issued to itself, at least in form, in order to make various insurance coverages available

to its employees and their dependents. The booklet-certificate of insurance issued to Smith states: "The Group Policy is a contract between the Policyholder ['Pilot Life Insurance Company (Ordinary Field Force)'] and Pilot Life...." There is no evidence of record suggesting that there has ever been a separate legal entity known as "Pilot Life Insurance Company (Ordinary Field Force)". Smith's employer was Pilot Life Insurance Company.

The first deduction from Crawford Smith's compensation account occurred on August 10, 1981 and paid the premium due for the month of August, 1981. The August deduction was not a computer-generated deduction, but was calculated and carried out by a clerk working outside Jefferson-Pilot's computerized deduction system. In the next month, September, 1981, even though the employer-insurer had agreed to deduct a premium each month, no premium deduction was

made by Jefferson-Pilot from Smith's compensation account at any time during that month, in spite of the fact that Smith's account had sufficient funds during September, 1981 to allow for the deduction.

Neither in September, 1981, nor thereafter during Crawford Smith's employment of some five years' duration, did Jefferson-Pilot request of Smith that he pay the September premium. Though Smith was unaware of the arrearage (referred to by the Eleventh Circuit as the "long standing arrearage") because of Jefferson-Pilot's failure to inform him of its existence throughout the remaining years of his employment, the insurer-employer's failure to deduct and collect a premium for September, 1981 resulted in all subsequent deductions of premiums by Jefferson-Pilot, and payment of premiums by Smith, to be at least thirty days in arrears, according to Jefferson-Pilot's contentions, thereby

effectively eliminating the thirty day grace period provided for in Smith's application for coverage and the insurance agreement between the parties.

During October, November and December of 1981, computerized premium deductions were made by Jefferson-Pilot from Crawford Smith's compensation account, and the payment for Smith's dependent coverage was credited in due course.

In December of 1981, Crawford Smith's wife, Jeannie Smith, suffered a cerebral vascular accident and incurred significant and continuing medical and nursing bills thereafter. These bills were submitted to Jefferson-Pilot for payment and were actually paid until June of 1986 when the insurer-employer terminated Smith's dependents' coverage for his wife in the circumstances hereinafter described, giving rise to this litigation. Between December, 1981 and June, 1986, Jefferson-Pilot

frequently complained about paying the bills and on at least one occasion suspended payment of Jeannie Smith's medical bills for a period of about two months, causing Smith great financial hardship. Smith's wife, Jeannie, passed away in June of 1990 as a consequence of the cerebral vascular accident which she sustained in 1981. Smith is the duly acting executor under her will, though there has been no formal substitution of parties.

Throughout each of the years 1982, 1983, 1984 and 1985 twelve regular monthly deductions were made from Crawford Smith's compensation account in payment of the premium due for his dependents' health coverage. In 1986, regular monthly computerized deductions were made in January, February and March. On March 31, 1986, for the first time since the inception of Crawford Smith's dependents' coverage, insufficient funds existed in Smith's

compensation account to cover the computerized deduction which was to be made on the first business day of April, 1986 in payment of the premium which Jefferson-Pilot contends was due March 1, 1986. Jefferson-Pilot sent a letter dated April 7, 1986 (38 days after the alleged due date of the premium) to Smith in care of its regional office in Macon, Georgia notifying Smith of the deficiency in his compensation account and requesting payment by check. Smith purchased a money order in the amount of $80.50 on April 16, 1986 and forwarded it to the insurer-employer. Jefferson-Pilot credited this payment to Smith's premium account on April 28, 1986, approximately 59 days after the contended March 1 due date for the March, 1986 premium. Crawford Smith's major medical coverage for his wife thus continued in force.

On May 1, 1986, a regular computerized deduction was made from Smith's compensation

account in payment of the monthly premium contended by Jefferson-Pilot to be due on April 1, 1986. However, on May 31, 1986, the balance in Crawford Smith's compensation account was only $16.47. Jefferson-Pilot contends that because of this small balance at the end of May, it was unable to deduct on Monday, June 2, 1986, the premium from Smith's compensation account which Jefferson-Pilot contends was actually due on May 1, 1986.

June 2, 1986, a Monday, is the day which Jefferson-Pilot, under oath, has identified in interrogatory answers as the latest date on which Smith could be allowed to pay the May 1 premium. However, on June 2, 1986, this very day, and the day on which Jefferson-Pilot contends it was unable to deduct the premium due on May 1 because of the insufficiency of funds in Smith's account, the employer-insurer in fact credited to Smith's compensation account

commissions on two policies, and the balance in Smith's compensation account immediately became sufficient on that very day to cover the deduction of Smith's monthly premium in the amount of $80.50.

In spite of Jefferson-Pilot's duty which arose from its insurance arrangements with Crawford Smith to deal with his funds so as to pay the premium and keep the dependents' coverage in force, Jefferson-Pilot made no deduction. On June 12, 1986, additional commissions were credited to Smith's compensation account which would have paid another month's premium, and later in June further commissions were credited to Smith's account so that the account balance was sufficient to cover five months' premiums (including the premium which Jefferson-Pilot refused to deduct on June 2, 1986). Notwithstanding the accumulating balance in Smith's compensation account during June, the employer-insurer continued

to refuse to make any deduction of the premium necessary to keep Crawford Smith's dependents' coverage in force.

Jefferson-Pilot's administrative employee who dealt with Smith's dependents' coverage showed that Smith's premiums were paid "current" in her initial processing of three separate group health insurance claim forms submitted by Smith in June, including one dated as late as June 17, 1986. In spite of the fact that Jefferson-Pilot's own internal claims processing documentation acknowledged that Crawford Smith's dependents' coverage was paid current as late as June 17, 1986, so that coverage would have been in place throughout May and June, Jefferson-Pilot sent "inter-office correspondence" to Smith on June 20, 1986 informing him that his dependents' major medical coverage was being lapsed as of May 1, 1986 for nonpayment of the May premium:

"June 20, 1986

Crawford B. Smith, Jr.
270 [indicating Macon, Georgia office]

DEPENDENT COVERAGE

This letter is to inform you that since there were not enough funds in your account to pay your May premium of $80.50 for continued major medical coverage on your dependents, we had no choice but to lapse your coverage on your dependents effective 5-1-86." (emphasis added).

Jefferson-Pilot's June 20, 1986 notification to Smith that his dependents' coverage had been cancelled as of May 1, 1986 occurred approximately 51 days after the alleged "due date" of the May premium. Smith never received any notice in advance of Jefferson-Pilot's June 20, 1986 notification of already-effected cancellation that his dependents' coverage would be cancelled, lapsed, terminated or ended (howsoever described) if payment of a premium were not made.

After Jefferson-Pilot's correspondence of June 20, 1986 to Smith informing him that the insurer-employer had no choice but to "lapse" his coverage effective May 1, 1986, Smith reacted immediately and took numerous actions in an unsuccessful effort to reinstate his dependents' coverage. However, Jefferson-Pilot refused to reinstate the coverage and made no more payments to Jeannie Smith, or for her benefit, on claims made under the policy. Shortly after Jefferson-Pilot rejected Smith's initiatives to have his wife's coverage reinstated, the employer-insurer suddenly and without notice terminated Smith's employment effective August 1, 1986.

VIII. ARGUMENT/REASONS FOR GRANTING WRIT OF CERTIORARI

The decision of the United States Court of Appeals below should be reviewed for the reasons hereinafter set forth under Arguments A and B.

A. ERISA'S SAVING CLAUSE OPERATES TO PREVENT THE PREEMPTION OF PETITIONERS' STATE LAW CAUSES OF ACTION GROUNDED UPON RESPONDENT'S VIOLATION OF GEORGIA'S WRITTEN NOTICE OF CANCELLATION STATUTE, O.C.G.A. §33-24-44(d).

Petitioners believe that the decision of the United States Court of Appeals below should be reviewed because it misconstrues and misapplies this Court's decisions as to the scope of ERISA's "saving clause", 29 U.S.C. §1144(b)(2)(A). The Eleventh Circuit would limit the scope and application of the saving clause so severely as to thwart congressional intent and any reasonable application of the saving clause. The Eleventh Circuit's decision below conflicts with the decisions of at least two other United States courts of appeal.

Petitioners' state law causes of action are grounded upon Respondent-insurer's failure to have given the advance written notice of cancellation required by Georgia's written notice of cancellation statute,

O.C.G.A. §33-24-44(d). The Eleventh Circuit accepted that "[i]t would seem to be clear that the defendant [Respondent] did not give notice under the terms of this statute...." Smith v. Jefferson Pilot Life Ins. Co., 14 F.3d 562, 569 (11th Cir. 1994), at Footnote 7.

Among those aspects of the Eleventh Circuit's decision below which Petitioners believe to be erroneous (and in conflict with the decisions and apparent views of at least the Third and Fifth Circuits) is the Eleventh Circuit's interpretation of this Court's requirement that in order to be "saved" as a state law which regulates insurance, the state law in question, among others criteria, must be directed at a " 'practice [which] has the effect of transferring or spreading a policyholder's risk....' " Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 743, 105 S. Ct. 2380, 2391, 85 L.Ed.2d 728 (1985), quoting

from Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 129, 102 S. Ct. 3002, 3009, 73 L.Ed.2d 647 (1982) and incorporating Pireno's McCarran-Ferguson Act criteria into saving clause analysis under ERISA.

In its decision below, the Eleventh Circuit appears to hold that a state law which meets the risk-spreading criterion or requirement enunciated by this Court in Pireno and Metropolitan Life must be focused upon, and possibly exclusively focused upon, the nature of the coverage of insurance policies, rather than being concerned with the more fundamental and generally accepted insurance function of spreading a risk or risks from an individual insured to an insurer, or into a pool of similar risks, through the insurance policy.

According to the Eleventh Circuit: "The Supreme Court has explained that the risk-spreading principle concerns the nature of the coverage of the policy - in other

words, the risks of injury that the insurance company will bear for the insured." Smith, below, 14 F.3d at 569. Petitioners respectfully submit that the Eleventh Circuit has misinterpreted "the risk-spreading principle" as it is generally understood. See, e.g., Couch On Insurance 2d,(Rev.ed 1984) §1.3, pp. 6-7.

(1) THE GEORGIA NOTICE OF CANCELLATION STATUTE IS CONCERNED WITH RISK-SPREADING

The current state of the law on the application and effect of ERISA's "saving clause" is that this Court has adopted a two-stage mode of analysis. See Pilot Life Insurance Co., v. Dedeaux, 481 U.S. 41, 107 S. Ct. 1549, 95 L.Ed.2d 39 (1987) and Metropolitan Life -- and, where the so-called "deemer" clause (29 U.S.C. §1144(b)(2)(B)) might apply to limit the saving clause, there is actually a three-stage analysis which has been clarified somewhat by this Court's decision in FMC

Corp. v. Holliday, 498 U.S. 52, 111 S. Ct. 403, 112 L.Ed.2d 356 (1990).

In the prescribed method of analysis, this Court first applies a "common sense" test to see if the state law in question can reasonably be said to regulate insurance. In the second stage of the analysis, this Court then applies three additional criteria to the state law to determine whether it is a law directed at the "business of insurance" for purposes of the McCarran-Ferguson Act. These three McCarran-Ferguson criteria are: " '[f]irst, whether the practice [with which the state law is concerned] has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.' " Metropolitan Life Ins. Co., supra, 471 U.S. at 743, 105 S. Ct.

at 2391, quoting from Pireno, supra, 458 U.S. at 129, 102 S. Ct. at 3009 (emphasis that of the Pireno Court). See also Pilot Life, supra, 481 U.S. at 48-49, 107 S. Ct. at 1553-1554.

If the state law in question is found to be one "which regulates insurance", a third stage of judicial analysis must then often be made into whether the so-called "deemer clause", 29 USC §1144(b) (2)(B), operates to prevent the state law in question from being treated as a law "which regulates insurance". FMC Corp., supra.

In the instant case, the Georgia statute which was offended by Respondent's conduct in cancelling Crawford Smith's dependents' health coverage without first giving the prescribed advance written notice is O.C.G.A. §33-24-44(d). See General American Life Ins. Co. v. Samples, 167 Ga. App. 622, 623, 307 S.E.2d 51, 52 (1983). The Court of Appeals of Georgia has

determined relatively recently that the wrongful cancellation of an insurance policy by a violation of O.C.G.A. §33-24-44 gives rise to an action in tort, and not merely to an action for breach of contract. See WMH, Inc. v. Thomas, 195 Ga. App. 61, 63, 392 S.E.2d 539, 542-43 (1990), reversed on grounds not here relevant, WMH, Inc. v. Thomas, 260 Ga. 654, 398 S.E.2d 196 (1990).

Georgia's written notice of cancellation statute, O.C.G.A. §33-24-44(d), provides in pertinent part as follows:

> "(d) When a policy is canceled for failure of the named insured to discharge when due any of his obligations in connection with the payment of premiums for a policy or any installment of premiums due, whether payable directly to the insurer or indirectly to the agent, or when a policy that has been in effect for less than 60 days is canceled for any reason, the notice requirements of this Code section may be satisfied by delivering or mailing written notice to the named insured and any lienholder, where applicable, at least ten days prior to the effective date of cancellation in lieu of the number of days' notice otherwise required by this Code section."

Though the Eleventh Circuit concluded that Georgia's written notice of cancellation statute passed the "common sense" test, that Court concluded that the statute failed to meet all three prongs of the McCarran-Ferguson "business of insurance" test which have been engrafted on to saving clause analysis by this Court's decisions in Metropolitan Life and Pilot Life, supra. The Eleventh Circuit determined that the first and third prongs of the Pireno/McCarran-Ferguson Act test had not been met.

Petitioners have already mentioned the Eleventh Circuit's apparent holding that the risk-spreading principle is concerned only with the nature of the coverage of the policy -- that is, what risks of injury or loss the insurance company will bear for the insured. The Eleventh Circuit's notion is completely contrary to this Court's analysis in Pireno, supra, and is also contrary to

the generally accepted understanding of the meaning of risk-spreading in the context of an insurance contract (even though the decision below actually cites Pireno as authority for the proposition that "the risk-spreading" principle concerns the nature of the coverage of the policy). Smith, below, 14 F.3d at 569.

Risk-spreading refers most fundamentally to the transfer of risk from an individual insured to an insurer. "Insurance necessarily involves two elements: a risk of loss to which one party is subject and a shifting of that risk to another party; and distribution of risk among similarly situated persons." 44 C.J.S., Insurance, §2, p. 74. See, e.g., Group Life & Health Ins. Co. v. Royal Drug Co., a McCarran-Ferguson Act case, 440 U.S. 205, 211-212, 99 S. Ct. 1067, 1073-74, 59 L.Ed.2d 261 (1979). See also the discussion by Justice Ginsburg, in a different ERISA

context than saving clause analysis, of the essential concept of insurance (as spreading the risk between insured and insurer) in this Court's recent opinion in John Hancock Mutual Life Insurance Co. v. Harris Trust & Savings Bank, ____ U.S. _____, 114 S. Ct. 517, 527 ____ L.Ed.2d ____ (1993).

In Pireno itself, this Court focused upon the transfer of risk from insured to insurer, and emphasized that the transfer is completed when the contract of insurance is entered into. This Court in Pireno has made it clear that the existence (or not) of the contract of insurance is the essence of risk-spreading: "The transfer of risk from insured to insurer is effected by means of the contract between the parties - the insurance policy - and that transfer is complete at the time that the contract is entered." Pireno, 458 U.S. 130, 102 S. Ct. 3009. Petitioners believe it necessarily follows that the risk is transferred back to

the insured individual when a contract or policy or insurance coverage is cancelled by the insurance company.

The Georgia statute is specifically directed at this transfer back to the insured of the previously-spread risk. This Court's having held in Metropolitan Life, supra, that a state law mandating coverage of certain risks is also concerned with risk-spreading hardly justifies the Eleventh Circuit's conclusion that the Georgia statute which is concerned with the basic transfer of risk from insured to insurer, and which is intended to maintain the existing spreading of a previously transferred risk, is not more fundamentally concerned with the "risk-spreading principle" than laws which merely mandate the coverage of particular risks.

The United States Courts of Appeal for the Third and Fifth Circuits appear to have concluded that state statutes which

establish conditions precedent to an insurer's power to cancel pre-existing coverage (i.e., so as to shift the risk back to the insured) do indeed fall within the scope of ERISA's saving clause. See Ticor Title Ins. Co. v. Federal Trade Commission, 998 F.2d 1129, 1134 (3rd Cir. 1993) and Gahn v. Allstate Life Insurance Co., 926 F.2d 1449, 1454 (5th Cir. 1991).

In Ticor, a McCarran-Ferguson Act case on remand from this Court, the Third Circuit observed with apparent approval that the Fifth Circuit in Gahn had determined that all three Pireno criteria were satisfied by a Louisiana statute "which precluded medical insurers from discontinuing coverage after a policyholder was diagnosed with a terminal illness...." Id., 998 F.2d at 1134. The Third Circuit in Ticor then conceptualized the Louisiana statute at issue in Gahn as follows: "The state statute the court considered in Gahn established certain

conditions precedent to an insurer's power to cancel a pre-existing insurance contract. As such, the statute affected the substantive terms of the insurance contract, and thus squarely regulated insurance under ERISA's exemption of state insurance law from preemption.... An insurer's... cancellation of a pre-existing health insurance policy would transfer risk from the insurer to the insured." Ticor, 998 F.2d at 1134 (emphasis added).

Georgia's notice of cancellation statute operates similarly in a functional sense. It too sets out a condition precedent to an insurer's power to transfer risk back to the insured; it too is concerned with risk-spreading; and it too squarely regulates insurance under ERISA's saving clause which exempts state insurance law from preemption.

(2) GEORGIA'S NOTICE OF CANCELLATION STATUTE IS DIRECTED AT AN INTEGRAL PART OF THE POLICY RELATIONSHIP BETWEEN THE INSURER AND THE INSURED

The Eleventh Circuit also determined that the Georgia notice of cancellation statute did not affect an integral part of the relationship between the insurer and the insured. Petitioners would ask how a statute which is directed at maintaining the very existence of insurance coverage (the existence of the contractual relationship) can be seen as not affecting an integral part of the relationship between the insurer and the insured? The Eleventh Circuit passes off the Georgia notice of cancellation statute as setting up a mere administrative requirement -- "[i]n other words the kind of notice that is required in order to terminate coverage is a matter that lies at the core of plan administration.... The statute in this case regulates the administration of policies, not their

substantive terms." Smith, below, 14 F.3d at 570.

Though the Eleventh Circuit concluded that Georgia's notice of cancellation statute did not meet the second prong of the "business of insurance" analysis, that Court acknowledged that the second prong question "provides a closer issue". Ibid. As observed above, the Third and Fifth Circuits have determined without equivocation that a state statute which establishes conditions precedent to an insurer's power to cancel a pre-existing insurance contract satisfies all three of the Pireno criteria. Ticor, supra, 998 F.2d at 1134; Gahn, supra, 926 F.2d at 1454. In the words of the Third Circuit: "The promise to indemnify against an unforeseen event [illnesses of certain types] is integral, i.e. encompassed within, to the insurer-insured relationship." Ticor, 998 F.2d at 1134. (emphasis added).

Petitioners would also observe that in this case there was a direct contractual relationship between Respondent-insurer, Jefferson-Pilot, and plaintiff Crawford Smith -- because Respondent was both his insurer and his employer. In Gahn, there appears to have been no direct policy relationship between the insurer, Allstate, and the insured Gahns. The policyholder of the group policy in Gahn was a multi-employer trust. However, this aspect did not concern the Fifth Circuit. Cf., Samples, supra, in which the Georgia Court of Appeals applied Georgia's notice of cancellation statute to an insurer's termination of an employee's dependents' coverage under a group insurance policy issued to the employer.

(3) IF GEORGIA'S NOTICE OF CANCELLATION STATUTE IS SAVED FROM ERISA PREEMPTION, THEN ALL CAUSES OF ACTION ARISING UNDER THAT STATUTE ARE ALSO SAVED

In its decision below, even though the Eleventh Circuit determined that the Georgia notice of cancellation statute was not saved from ERISA preemption, that Court went on to suggest that Petitioners' tort claims arising under the Georgia statute "would clearly be preempted", apparently meaning that the Smiths' causes of action or remedies would be preempted even if the Georgia notice statute itself were otherwise saved from ERISA preemption by the operation of the saving clause. The Eleventh Circuit's view is predicated on what it calls "[t]he second half of Pilot Life." Smith, below, Footnote 12, 14 F.3d at 571.

The basis for interpreting this Court's earlier decision in Pilot Life as limiting available remedies under a "saved" state law to those remedies allowed under ERISA is the

notion that this Court's insurance regulation and exclusive remedy discussions in Pilot Life amount to independent, alternative holdings. Petitioners submit that this is an illogical and fundamentally erroneous interpretation. See, e.g., the reasoning of the United States District Court for the Northern District of California in Graves v. Blue Cross of California, 688 F. Supp., 1405, 1413 (N.D. Cal. 1988).

In the view of the United States District Court in Graves, the insurance regulation and exclusive remedy discussions in Pilot Life are not independent, alternative holdings, "but [are] inter-dependent considerations supporting the Court's conclusion that the saving clause does not apply." Graves, 688 F. Supp. at 1413 and footnote 10. See also this Court's actual holding in the final paragraph of Pilot Life which makes plain that this Court

took into account a mix of relevant factors -- considering together the common sense understanding of the saving clause, the three McCarran-Ferguson Act factors, and the congressional intent that ERISA's civil enforcement scheme be exclusive. Pilot Life, 481 U.S. 57, 107 S. Ct. 1558. If this Court's exclusivity of remedy analysis alone were sufficient to displace the state law, even where that law qualifies as a law "which regulates insurance", then the bulk of this Court's opinion in Pilot Life would have been superfluous. There would have been no need whatever for this Court to have engaged at all in the McCarran-Ferguson "business of insurance" analysis.

The United States Court of Appeals in Tomczyk v. Blue Cross and Blue Shield United of Wisconsin, 951 F.2d 771, 776 (7th Cir. 1991) has indicated that it holds a view of the effect of salvation under the saving clause which is similar to the contentions

of Petitioners herein. The Seventh Circuit, in discussing this Court's Pilot Life decision, 951 F.2d at 775-76, observed that this Court relied primarily "on three rationales" in deciding Pilot Life. These were, first, that the Mississippi bad faith law at issue in Pilot Life was not specifically directed toward the insurance industry; secondly, that the Mississippi general law of bad faith did not meet all three prongs of the McCarran-Ferguson test (especially in that it was not directed to transferring or spreading the risk and was not directed to integral part of the policy relationship); and, thirdly, "allowing the law to escape preemption would violate congressional intent regarding the exclusivity of ERISA's civil enforcement scheme." Tomczyk, 951 F.2d at 776 (emphasis added). It thus appears to Petitioners that the Seventh Circuit viewed this Court's discussion in Pilot Life of the exclusivity

of ERISA's civil enforcement scheme as simply providing a bolstering reason to interpret the insurance "saving clause" narrowly, and to limit its application to laws which are directly focused upon the "business of insurance".

Petitioners also suggest (and contend) that this Court's decision in FMC Corp., supra, signals a significant shift in emphasis as to the relative importance of maintaining, at all costs, the exclusivity of ERISA's civil enforcement scheme and the primacy of ERISA's core concerns -- when faced with a state law which is clearly saved from preemption by the saving clause.

In FMC Corp., this Court concluded that an insurance company which insures an ERISA plan is bound by state laws "purporting to regulate insurance": "The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance

regulations insofar as they apply to the plan's insurer." FMC Corp., ____ U.S. _____, 111 S. Ct. at 409.

FMC Corp. declares broadly and in point-blank fashion that if a state law which regulates insurance is saved, then it is absolutely saved, unless the "deemer clause" alone precludes application of the saving clause. FMC Corp., _____ U.S. _____, 111 S. Ct. 409-10. See especially this Court's own emphasis, in italics, upon "[e]xcept as provided in [the deemer clause]" at ____ U.S. _____, 111 S. Ct. 409. The implication of FMC Corp. is that if a state law regulating insurance is "saved", then it is absolutely saved, with no limitation on a claimant's remedies under the saved law to those remedies which are consistent with ERISA's "core concerns" or remedial scheme.

In FMC Corp., the plaintiff-employer, FMC, as operator of a self-funded health

plan, sued the daughter of its employee to recover (or to have the United States District Court declare that it was entitled to recover), as a subrogation right, the portion of the daughter's medical expenses which had been paid by the plan and recovered in her behalf by means of an automobile negligence action against the driver of the automobile in which the daughter was injured. The employee and his daughter resisted the employer's subrogation claim and asserted that Pennsylvania's anti-subrogation statute prevented any recovery by FMC, the employer.

This Court in FMC Corp. expressly declared the Pennsylvania anti-subrogation statute to be within the scope of the saving clause if it had been applied to an insured plan, as distinguished from a self-funded plan. Employer-FMC's health plan, at odds with Pennsylvania's anti-subrogation statute, specifically accorded the employer

a right of subrogation, and the employer was faced with what this Court acknowledged would have been a "patch work scheme of regulation" introducing significant inefficiencies if the ERISA preemption clause did not apply so as to cause the benefit plan to be governed by only a single set of regulations. FMC Corp., ____ U.S. _____, 111 S. Ct. at 408. This uniformity is a "core concern" of ERISA, as is ERISA's civil enforcement scheme set out in 29 USC §1132.

In FMC Corp., the very lawsuit filed by the employer, FMC, as plan fiduciary (the complaint seeking a declaratory judgment) itself formed part of ERISA's civil enforcement scheme. See 29 USC §1132(c), which authorizes a fiduciary (or any beneficiary or participant as well) to enjoin acts or practices which violate any provision of Title 29 or "the terms of the plan....", and to "enforce... the terms of

the plan." (emphasis added). In FMC Corp., the employer-plan fiduciary, by means of the declaratory judgment action, was seeking to enforce the terms of the plan.

In the face of this suit by the employer to enforce the terms of the plan, squarely pursuant to ERISA's civil enforcement scheme and in accord with a core concern of ERISA that plan administrators and fiduciaries be able to interpret and apply the plan on a consistent uniform basis, this Court in FMC Corp. unequivocally declared, in essence, that the Pennsylvania Anti-Subrogation Statute was within the exception of the "saving clause", and would have applied to defeat the plan's subrogation recovery against the employee and the employee's daughter, if the plan had been an insured plan. Solely because the FMC plan was a self-funded plan, the "deemer" clause operated to prevent Pennsylvania law from deeming the self-

funded plan "to be an insurance company or other insurer... or to be engaged in the business of insurance...." FMC Corp., ____ U.S. _____, 111 S. Ct. 409.

The opinion of the Court in FMC Corp. draws an express distinction between ERISA plans funded by insurance and ERISA plans which are not funded by insurance. This Court determined in FMC Corp. that where there is an insured plan, the contracts of the insurers "are subject to direct state regulation..." and stated "[w]e observe Congress' presumed desire to reserve to the States the regulation of the 'business of insurance'." FMC Corp., ____ U.S. _____, 111 St. Ct. 410. "Our interpretation... makes clear that if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts...." FMC Corp., ____ U.S. _____, 111 St. Ct. 411.

Finally, Petitioners would respectfully point to the plain language of ERISA's saving clause which this Court noted in FMC Corp. The saving clause is clear in providing that, except for the so-called deemer clause, "nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance...." 29 U.S.C. §1144(b)(2)(A) (emphasis added).

Because ERISA's civil enforcement provisions (29 U.S.C. §1132) are contained in the same title (indeed the same subchapter) as the saving clause, the plain language of the statute precludes any reasonable holding that state laws falling within the ambit of the saving clause are nonetheless preempted, or are otherwise limited even if "saved", where the operation of the state law and the assertion of causes of action arising thereunder interfere with

ERISA's civil enforcement scheme and core concerns.

Any such holding, as well as the analysis of the Eleventh Circuit below, would require a rewriting of the saving clause so that it would contain an added proviso or exception, something like the following: "Except as provided in subparagraph (B) and in §1132 establishing the civil enforcement scheme, nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities." (hypothetical new matter added in italics).

B. THE DEPARTMENT OF LABOR'S REGULATION, 29 CFR §2510.3-1(e), REMOVES RESPONDENT'S HEALTH INSURANCE PLAN OR PROGRAM AT ISSUE FROM ERISA'S SCOPE

29 CFR §2510.103(e) provides:

> "(e) Sales to employees. For purposes of Title I of the Act and this chapter, the terms 'employee welfare benefit plan' and 'welfare plan' shall not

> include the sale by an employer to employees of an employer, whether or not at prevailing market prices, of articles or commodities of the kind which the employer offers for sale in the regular course of business." (emphasis supplied).

The decision below should be reviewed because it construes the Department of Labor's Regulation, 29 CFR §2510.3-1(e) (hereinafter, "Paragraph e") in an erroneous, if not unreasonable, manner. The proper construction of Paragraph (e) of the Regulations presents a matter of first impression to this Court. Petitioners contend that the program by which Respondent furnished health insurance coverage to the Smiths is excluded from ERISA's scope by Paragraph (e). Paragraph (e) excludes from ERISA's reach an employer's sale to its employees of products which the employer sells in the ordinary course of business, even if made available to the employee on a bargain basis.

Petitioners believe that Paragraph (e) has been the subject of judicial construction in only two cases -- the instant litigation and Kristina Eaton v. Delta Airlines, Inc., No. C87-748(C)(WD), an unreported decision of the United States District Court for the Western District of Washington entered May 27, 1988, vacated in irrelevant part on September 7, 1988, and unofficially reported as Lexis No. 15986.

The insurance product which Smith's employer, Jefferson-Pilot, sold to him fits squarely within Paragraph (e) in a conceptual sense. Paragraph (e) makes plain that the sale by an employer to its employees of the very product which the employer offers for sale in the regular course of business is not a welfare plan within the definition of ERISA. In the instant case, Jefferson-Pilot was both employer and insurer and made available a health insurance product to its employee,

Crawford Smith, for his wife, Jeannie Smith, which was identical or substantially similar to that which Jefferson-Pilot offered for sale in the regular course of its business.

The insurance coverage was made available through a group policy which purported to run between Pilot Life Insurance Company, as Smith's employer, and Pilot Life Insurance Company, as an insurer. The booklet-certificate of insurance issued to Smith defines Pilot Life Insurance Company, the employer, as both insurer and "Policyholder" and goes on to state: "The Group Policy is a contract between the Policyholder ['Pilot Life Insurance Company (Ordinary Field Force)'] and Pilot Life...." There is no evidence of record suggesting or indicating that there has ever been a separate legal entity known as "Pilot Life Insurance Company (Ordinary Field Force)".

Pursuant to the Respondent-employer's program of making available its own

insurance product to its employees and their dependents, Jefferson-Pilot provided and sold health insurance coverage to Petitioner Crawford Smith in consideration of his services (and without any payment from him other than his services). Petitioners contend that Jefferson-Pilot's provision of health coverage to the employee, Crawford Smith himself, and its sale to Smith of health coverage for his dependent wife, Jeannie, are both within the exclusion from ERISA coverage of Paragraph (e) of the Regulations.

Even if the coverage afforded Crawford Smith and the coverage afforded his dependent wife are part of the same program or "plan" (a program or plan that might otherwise constitute an ERISA plan), nonetheless both coverages are excluded from ERISA's scope under Paragraph (e) of the Regulations. The Respondent-employer provided and sold to its employee, Crawford

Smith, his coverage as additional compensation and in consideration of his services. Paragraph (e) applies to sales by the employer, even at bargain prices ("whether or not at prevailing market prices") of the products which the employer offers for sale in the regular course of business. Respondent-employer sold to Smith coverage for his dependent wife for a monetary consideration. If a benefit plan falls within the scope of an exclusionary regulation of the Department of Labor, even though it is a benefit plan which would otherwise constitute an ERISA plan, "then ERISA does not cover that plan...." Hansen v. Continental Ins. Co., 940 F.2d 971, 976 (5th Cir. 1991).

Paragraph (e) of the Regulations by its terms applies only to an "article" or a "commodity". It is a basic principle of statutory construction that ordinary words must be given their ordinary or dictionary

meaning. In the only judicial decision known to Petitioners which attempts to discern the meaning of "articles or commodities" for purposes of Paragraph (e), the United States District Court for the Western District of Washington turned to dictionary definitions in order to arrive at the meaning of "commodities". Kristina Eaton v. Delta Airlines, Inc., supra, unofficially reported as Lexis No. 15986.

Webster's New Collegiate Dictionary (1979) defines "article", in the commercial context, to mean any item or matter of business. The 1979 edition's definition of "article" is in pertinent part as follows, on page 63 of the dictionary:

> "1. a: a distinct often numbered section of a writing b: a separate clause c: a stipulation in a document (as a contract or a creed) d: a nonfictional prose composition usu. forming an independent part of a publication (as a magazine) 2: an item of business: MATTER ...." (emphasis added).

The essential definition of "article" in the commercial or business context in the 1979 edition of Webster's New Collegiate is that "article" imports any item of business or any business matter. An insurance policy or insurance coverage, at a minimum, must surely import an item of business or a business matter.

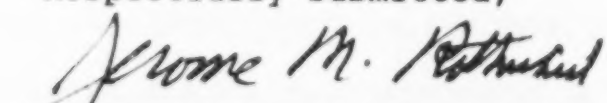
In accepted current business and marketing usage, insurance policies are referred to as "insurance products". Insurance policies are products of the insurance industry, intended for sale to consumers of insurance products, as much as automobiles are products of automobile manufacturers which are intended for sale to consumers. Petitioners submit that there is no sound reason under Paragraph (e) of the Regulations to distinguish a tangible product sold in commerce, such as an automobile, from a commercial product in the nature of a contract right, such as an

insurance policy, or from any other contract right to insurance coverage. Both product types fall within a reasonable dictionary definition of "article" in the business context, as set out above, to include any item or matter of business.

IX. CONCLUSION

For all the foregoing reasons, Petitioners believe this Court should review the decision below of the United States Court of Appeals for the Eleventh Circuit and reverse that Court's decision and judgment.

Respectfully submitted,



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APPENDIX

OPINIONS, JUDGMENTS AND ORDERS BELOW

AND

STATUTES AND REGULATIONS

INVOLVED

IN THE UNITED STATES COURT OF APPEALS

FOR THE ELEVENTH CIRCUIT

No. 92-8934

D. C. Docket No. 87-124-COL

CRAWFORD B. SMITH, JR., and JEANNIE SMITH,

Plaintiffs-Appellees

versus

JEFFERSON PILOT LIFE INSURANCE COMPANY,

Defendant-Appellant.

Appeal from the United States District Court for the Middle District of Georgia

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(February 2, 1994)

Before ANDERSON and CARNES, Circuit Judges, and MERRYDAY*, District Judge

ANDERSON, Circuit Judge:

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*Honorable Steven D. Merryday, U.S. District Judge for the Middle District of Florida, sitting by designation

Plaintiffs Crawford B. Smith, Jr. and Jeannie Smith brought this suit against Jefferson-Pilot Life Insurance Company in the Superior Court of Muscogee County, Georgia, seeking damages for tortious termination of Jeannie Smith's major medical health coverage. The defendant removed the case to federal court based on diversity. The plaintiffs filed a motion for partial summary judgment contending (1) that the dependent medical coverage provided to Jeannie Smith was not a plan under the Employee Retirement and Income Security Act ("ERISA"), and (2) that even if the coverage were part of an ERISA plan, the state statute underlying their tort claim escapes preemption through application of the ERISA "saving clause", 29 U.S.C. §1144(b)(2)(A). The district court granted the plaintiffs' motion on both grounds, and this court granted the defendant permission to make an interlocutory appeal on the district court

ruling. For the following reasons, we reverse on both grounds, and remand the case to the district court.

I. FACTS AND PROCEDURAL HISTORY

On August 1, 1981, plaintiff Crawford Smith began his employment with Pilot Life Insurance Company, a predecessor of the defendant, as a commission agent.[1] Smith elected to participate in the insurance plan offered by the defendant to its agent entitled "Group Life and Medical Insurance Plan for Agents and General Agents" (the "Plan"). The Plan was insured through an insurance policy, Group Insurance Policy No. 3469, issued by the defendant, who was both the employer and the insurer. All costs of the insurance for agents were paid by the defendant to the Plan. The Plan included a

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[1] The parties do not dispute that the defendant has assumed the obligations of Pilot Life, with whom the defendant merged in 1987, in this matter. For simplicity, this opinion will generally refer to Jefferson-Pilot.

dependent coverage feature whereby eligible dependents of the agents could obtain medical coverage. To obtain dependent coverage, agents were required to make a contribution for the premium. Only agents of the defendant and eligible dependents were able to participate in the Plan. Plaintiff Crawford B. Smith elected to obtain coverage for his wife, Jeannie Smith, through the Plan.

Jeannie Smith suffered a cerebral vascular accident in December of 1981, resulting in ongoing medical costs from that time until her death in June of 1990. The defendant paid these costs pursuant to the dependent coverage feature from 1981 until May 1986. The defendant maintains that the dependent coverage lapsed at that time for nonpayment of the employee contribution. Smith argues that the defendant tortiously terminated the dependent coverage. The termination of this coverage in 1986 forms

the basis of this lawsuit.

When Crawford Smith elected to pay for the dependent coverage feature, he authorized Jefferson-Pilot to deduct the premium for his wife's coverage from his compensation account. Crawford Smith's original Request for Group Insurance, dated July 7, 1981, contained the following authorization to deduct a monthly contribution:

> I authorize [Jefferson-Pilot] to deduct the above monthly amount from my monthly compensation. I agree if there are insufficient funds at that time, I must remit my personal check to [Jefferson-Pilot] to continue my coverage. I understand this check must be received by [Jefferson-Pilot] at it's Home Office not later than 30 days after the due date and if not received, all insurance lapses.

The record indicates that Smith's dependent coverage payments had technically been one month in arrears since the second month. This happened because Jefferson-Pilot made no deduction from Smith's compensation account for September 1981, even though

Smith's account contained sufficient funds for the deduction.[2] Smith did not send a check to cover the contribution, and he received no request for back payment. The missing deduction from September 1981 did not become an issue until the coverage was terminated in 1986. Following the Jefferson-Pilot error in failing to deduct the September 1981 premium, the monthly premiums were properly deducted from October 1981 until 1986. However, Jefferson-Pilot now argues that each such deduction actually paid the previous month's premium. We refer to this as the long-standing arrearage.

On March 31, 1986, Crawford Smith's compensation account contained insufficient funds to cover the computerized deduction to

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[2] There is some confusion in the record whether a deduction was made for September 1981. However, we assume for the purposes of this appeal that Jefferson-Pilot did not make a deduction from the plaintiff's account in September 1981. The record clearly indicates that a deduction was made in August 1981 for the August premium covering the dependent coverage.

be made on the next business day. Jefferson-Pilot sent correspondence to Smith dated April 7, 1986, requesting payment of the premium for the dependent coverage by check. Smith purchased a money order on April 16, 1986 and sent it to the defendant, and the payment was credited to Smith's account on April 18, 1986. This date was 27 days after the normal date on which the premium would be paid; thus, it fell within the 30 day grace period established by the terms of the Plan. However, including the long-standing arrearage, the payment was credited to his account 57 days after it was due. Under the calculation the coverage had lapsed the very day after the premium would normally have been paid.

Two months later the same thing happened again, as discussed below, but this time the defendant took the position that the policy had lapsed. On May 31, 1986, Smith's compensation account again fell

below the amount of the dependent coverage premium. Thus, the account contained insufficient funds on Sunday, June 1, 1986 to cover the deduction made by computer for the dependent coverage premium. The record shows that $90 in commissions were credited to the plaintiff's account on Monday June 2, 1986, which would have covered the required contribution. On June 12, commissions were credited to Smith's account that would have paid another month's premium. By then, however, according to the defendant's position, the coverage had lapsed for failure to make contributions required by the Plan within thirty days of the due date. Jefferson-Pilot's position is that, because of the long-standing one-month arrearage, the May 1 premium was 30 days overdue on June 1, and thus the coverage lapsed when the premium was not paid that day. Jefferson-Pilot states that it notified Smith that his premium had not been paid on

June 5 and that Smith did not respond. Therefore, on June 20, 1986, Jefferson-Pilot sent Smith a termination letter. That letter, sent to the plaintiff's office in Macon, Georgia, was intended to notify Smith that his coverage had lapsed for failure to pay the May contribution. Thus, Smith's coverage was terminated either 19 days after the premium was due on June 1, based on the procedures that had been in place since September 1981, or 49 days after it was due under the defendant's argument. Although Smith received statements reflecting the monthly deductions from his account; these statements did not state that the monthly deduction in fact paid the prior month's premium, as defendant now argues. Smith apparently learned of defendant's position for the first time during discovery. Smith's efforts to reinstate the coverage failed. Jefferson-Pilot paid no more benefits to Jeannie Smith for claims under

the policy.

On August 10, 1987, Crawford Smith and his wife sued Jefferson-Pilot in state court seeking actual and punitive damages for tortious termination of the dependent coverage. Based on diversity, Jefferson-Pilot removed the case to the United States District Court for the Middle District of Georgia. After extensive discovery, the defendant filed a motion for summary judgment on November 8, 1991, stating that the dependent coverage feature was part of an ERISA plan and that ERISA preempted the state law cause of action. On December 7, 1991, the plaintiff filed a cross motion for partial summary judgment, claiming first that the dependent coverage feature was not an ERISA plan. Alternatively, the plaintiff argued that even if the dependent coverage were part of an ERISA plan, the tort claim escapes preemption through the ERISA "savings clause", 29 U.S.C. §1144(b)(2)(A),

which excepts practices that regulate the business of insurance from preemption. The plaintiff grounded this argument on the theory that the tort claim is based on the defendant's violation of a Georgia statute, O.C.G.A. §33-24-44(d), which requires written notice of cancellation of insurance coverage. Since the Georgia statute regulates insurance, according to the plaintiff, it is "saved" from preemption, as is the tort cause of action based on its violation. The district court issued an order granting the plaintiff's partial motion on both grounds and denying the defendant's motion on April 20, 1992. On August 19, 1992, the district court certified this order for immediate interlocutory review pursuant to 28 U.S.C. §1292(b). We granted permission to appeal on September 28, 1992.

II. STANDARD OF REVIEW

We have plenary review of summary judgments, and we apply the same legal standards that controlled the district court. Miranda v. B & B Cash Grocery Store, 975 F.2d 1518, 1532 (11th Cir. 1992). We review the facts in the light most favorable to the non-movant and resolve all factual disputes in favor of the non-movant.

III. DISCUSSION

A. ERISA Governs the Dependent Coverage Feature.

Congress enacted ERISA, 29 U.S.C. §1001 et seq., to protect "the interests of participants in employee benefit plans and their beneficiaries...." 29 U.S.C. §1001. ERISA governs "employee benefit plans," Id. at §1003, and all "employee welfare benefit plans" are also "employee benefit plans." Id. at §1002(3). ERISA includes in its definition of an "employee welfare benefit

plan" any plan "established or maintained for the purpose of providing for its participants or their beneficiaries... medical, surgical, or hospital care or benefits, or benefits in the event of sickness, [or] accident...." 29 U.S.C. §1002(1)(A).

Both case law and Department of Labor regulations have refined the statutory definition of employee welfare benefit plans. There are five prerequisites for an ERISA welfare benefit plan: (1) a plan, fund, or program (2) established or maintained (3) by an employer (4) for the purpose of providing medical benefits (5) to participants or their beneficiaries. Donovan v. Dillingham, 688 F.2d 1367, 1371 (11th Cir. 1982). The Jefferson-Pilot Plan and its dependent coverage feature clearly meet these prerequisites. Jefferson-Pilot established the Plan to provide medical benefits exclusively for its agents and

participating dependents. Therefore, the coverage in the instant case qualifies as an employee welfare benefit plan under §1002(1)(A).

The district court, however, agreed with the plaintiff that ERISA did not apply to the dependent coverage provided to Jeannie Smith. Although it did articulate the specific grounds for its holding, the district court did not in its Memorandum and Order on Motions for Summary Judgment that the dependent coverage was "wholly paid for" by Crawford Smith. The plaintiff argues that regulations 29 C.F.R. §2510.-1(e) and (j) remove the dependent coverage from ERISA's reach. These regulations were promulgated by the Department of Labor to clarify the definition of an employee benefit plan under ERISA. 29 C.F.R. §2510.3-1(a).

Regulation 29 C.F.R. §2510.3-1(e) states:

> (e) Sales to employees. For purposes of title I of the Act and this chapter, the term "employee welfare benefit plan" and "welfare plan" shall not include the sale by an employer to employees of an employer, whether or not at prevailing market prices, of articles or commodities of the kind which the employer offers for sale in the regular course of business.

The plaintiff argues that §2510.3-1(e) applies to the instant case because Crawford Smith contributed the entire premium for the dependent coverage, and the coverage provided to Jeannie Smith was identical or substantially similar to the insurance policies that Jefferson-Pilot offered for sale to the public. In other words, they argue that Jefferson-Pilot sold the dependent coverage to the plaintiff. Although interpretation of this regulation is an issue of first impression, it is clear that §2510.3-1(e) does not apply to the dependent coverage feature contained in the Plan. The plaintiff seeks to sever the dependent coverage feature from the benefits

package provided to agents through the Plan. This cannot be done because the dependent coverage was a feature of the Plan, notwithstanding fact that the cost of such coverage had to be contributed by the employee. The plaintiff offers no case law to support the argument that dependent coverage features may be severed from the rest of an ERISA plan, and common sense compels the conclusion that ERISA regulation is not escaped merely by including such a commonplace feature of group plans.[3] The plain language of the regulation indicates that the regulation contemplates a situation where an individual, who incidentally is an employee of an insurance company, purchases

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[3] In another context, the Supreme Court refused to exempt a portion of a plan from ERISA that was designed to comply with New York disability laws, even though § 1003(b)(3) exempts plans from ERISA when the plan is solely designed to comply with state disability laws. Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 107 (1983). Thus, we may infer that, generally, ERISA plans may not be severed so that portions of them may be excluded from regulation under ERISA.

on an individual basis -- and not as part of an employee welfare benefit plan -- a product from that company. Section 2510.3-1(e) does not apply to situations where an employer-insurer has established an employee benefit plan where both the employee and the employer contribute part of the premium of the plan.[4]

Regulation 29 C.F.R. §2510.3-1(j) also does not apply to the dependent coverage feature. This is a "safe harbor" provision that excludes some programs for group insurance from the "employee welfare benefit

---

[4] Congress expressly contemplated the use of insurance to fund ERISA benefits since it defined covered programs as those funded "through the purchase of insurance or otherwise." 29 U.S.C. §1002(1). Furthermore, ERISA expressly permits insurer-employers to use their own insurance policies to fund ERISA governed benefits by exempting such transactions from the statute's prohibited transaction provisions. 29 U.S.C. §1108(b)(5). Thus, Jefferson-Pilot's issuance of its own policy to fund the Plan does not defeat ERISA coverage. The Secretary of Labor has also expressly acknowledged ERISA jurisdiction over plans that deduct employee contributions. 29 C.F.R. §2510.3-102.

plans" governed by ERISA.[5] Again, in relying upon this regulation, the plaintiff seeks to sever the dependent coverage from the rest of the benefits package the Smith's received from the Plan. For the reasons discussed above, we reject Smith's severance argument. We see no indication at all that

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[5] Regulation 29 C.F.R. §2510.3-1 (j) states in full:

> (j) Certain group or group-type insurance programs. For purposes of title I of the Act and this chapter, the terms "employee welfare benefit plan" and "welfare plan" shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which
>
> (1) No contributions are made by an employer or employee organization;
>
> (2) Participation [in] the program is completely voluntary for employees or members;
>
> (3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and
>
> (4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.

the regulation was intended to exempt from ERISA coverage the commonplace situation where dependent coverage is paid for by plan participants. The regulation applies only to programs where no contributions are made by an employer; yet under the Plan the defendant contributed all of the premium except for the dependent coverage contribution. The employer must not subsidize the purchase of insurance for this safe harbor provision to apply. See Randol v. Mid-West Nat. Life Ins. Co. of Tennessee, 987 F.2d 1547, 1550 (11th Cir. 1993).[6]

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[6] The plaintiff attempts to fortify his argument that 29 C.F.R. § 2510.3-1(j) excludes the Plan from ERISA by relying on Opinion Letter No. 83-3A of the Secretary of Labor. This reliance is misplaced. In that opinion the administrator advises a company that 2510.3-1(j) exempts from ERISA the company's policy of selling its standard insurance policies to employees of unrelated subsidiaries. This opinion letter only highlights the distinction between (1) a company that creates a distinct plan for its employees' medical insurance; and (2) a company that allows its employees to purchase individual policies from it or any other insurer. The instant case represents the former scenario, and is not covered by 2510.3-1(j).

For the foregoing reasons, we hold that ERISA governs the dependent coverage feature.

B. Preemption

The "preemption" clause of ERISA provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. §1144(a). The ERISA "saving clause", however, "saves" from ERISA preemption "any law of any State which regulates insurance, banking, or securities." 29 U.S.C. §1144(b)(2)(A). The plaintiff grounds his tort claim on a Georgia statute, O.C.G.A. §33-24-44(d).[7]

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[7] O.C.G.A. §33-24-44(d) is a notice provision of the Georgia insurance regulations that states in relevant part:

> (d) When a policy is canceled for failure of the named insured to discharge when due any of his obligations in connection with the payment of premiums for a policy or any installment of premiums due, whether payable directly to the insurer or indirectly to the agent . . . the notice requirements of this

Section 33-24-44(d), as applied to the Smith's dependent coverage, falls squarely under the preemption clause since it directly "relates to" an employee benefit plan. Plaintiff argues, however, that the statute regulates insurance, and thus escapes preemption by operation of the ERISA saving clause. The district court agreed. We must determine whether O.C.G.A. §33-24-44(d) regulates the business of insurance and is saved from preemption as applied to the coverage at issue.

> Code section may be satisfied by delivering or mailing written notice to the named insured and any lienholders, where applicable, at least ten days prior to the effective date of cancellation in lieu of the number of days' notice otherwise required by this Code section.

The plaintiff claims that Jefferson-Pilot violated this statute by lapsing the dependent coverage without complying with the statute. It would seem to be clear that the defendant did not give notice under the terms of this statute, and this would apparently be one ground on which the termination of coverage might be declared invalid. Another potential ground, wholly independent of the Georgia statute, involves the validity under federal law of Jefferson-Pilot's reliance on the long-standing one month arrearage.

Given the broad language of ERISA's preemption clause, and the saving clause's equally broad exception to preemption for laws that regulate insurance, courts have struggled to define which state laws regulate insurance for the purposes of ERISA. Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985), set forth the analysis for determining whether a state law is an insurance regulation. Subsequently, the Court reaffirmed the use of the Metropolitan Life analysis, but did so with a clear intent to create a narrower scope for the saving clause in light of the broad sweep of the preemption provision. See Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987). Thus, we apply the test for determining whether a state statute regulates insurance, mindful of ERISA's design to "establish pension plan regulation as exclusively a federal concern." Pilot Life, 481 U.S. at 46, quoting Alessi v.

Raybestos-Manhattan, Inc., 451 U.S. 504, 523 (1981). First, the state law must regulate insurance within a common-sense view of the word "regulate". Pilot Life, 481 U.S. at 50. Second, the state law must regulate the "business of insurance", as that term is defined by cases interpreting the scope of the McCarran-Ferguson Act. Metropolitan Life, 471 U.S. at 743.[8] The "business of insurance" test outlines three criteria for courts to consider in deciding whether a statute regulates insurance: (1) whether the law has the effect of transferring or spreading a policyholder's risk; (2) whether the law impacts an integral part of the policy relationship between the insurer and the insured; and (3) whether the law is

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[8] Congress enacted the McCarran-Ferguson Act, 15 U.S.C. §1011 et seq., to remove insurance companies from the scope of antitrust laws and to declare that "the continued regulation and taxation of the several States of the business of insurance is in the public interest." 15 U.S.C. §1011.

directed only at entities within the insurance industry. Id. We have held that ERISA preempts Alabama case law requiring notice of policy cancellation based on this analysis. Willett v. Blue Cross and Blue Shield of Alabama. 953 F.2d 1335 (11th Cir. 1992).

The statute in question clearly regulates insurance within the common-sense portion of the test. It expressly targets the insurance industry. See Pilot Life, 481 U.S. at 50. Next, we apply the three-pronged "business of insurance" test. Under the first prong of the test, O.C.G.A. §33-24-44(d) does not have the effect of transferring or spreading a policyholder's risk. The Supreme Court has explained that the risk-spreading principle concerns the nature of the coverage of the policy -- in other words, the risks of injury that the insurance company will bear for the insured. Union Labor Life Ins. Co. v. Pireno, 458

U.S. 119, 130 (1982). That transfer is complete at the time the contract is entered. Id.[9] O.C.G.A. §33-24-44(d) does not affect the apportionment of risks, i.e., what medical costs are covered, that the parties made upon entering the contract. This court also held in Willett, without comment, that Alabama's notice requirements did not spread risk under this analysis. 953 F.2d at 1341, n.6.

Application of the second prong of the

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[9] Thus, although a statute that prevents cancellation of a policy without notice arguably affects the transfer of risk, since it regulates the conditions under which the insurer must continue to bear risks for the insured, it does not alter the initial apportionment of risk among the parties at the inception of the contract. The first prong of the business of insurance test concerns only laws that impact the original apportionment of risks covered by the policy. The statute before us merely attempts to minimize the risk of noncoverage to persons whose policies lapse. See Tingle v. Pacific Mut. Ins. Co., 996 F.2d 105, 109 (5th Cir. 1993) (holding that a Louisiana law that false statements made on a policy application must have actual intent to deceive in order for them to bar recovery did not satisfy the first prong, because "[a]lthough the statute does shift the burden of innocent misrepresentations (the legal risk) onto the insurer, it does not spread the risk of insurance (health) coverage for which the parties contracted").

business of insurance analysis provides a closer issue. However, Willett held, again without comment, that Alabama's similar notice requirements do not affect an integral part of the relationship between the insurer and the insured. Id. Although the contours of the second criterion are somewhat vague, our analysis of its meaning, in light of the purpose of ERISA, leads us to same conclusion as Willett.

O.C.G.A. §33-24-44(d) relates to the administration of benefit plans that include insurance policies. In other words, the kind of notice that is required in order to terminate coverage is a matter that lies at the core of plan administration. ERISA is designed, however, to provide uniformity in the administration of benefit plans for the protection of plan participants. Fort Halifax Packing Co., Inc. v. Coyne, 482 U.S. 1, 9 (1987); Pilot Life, 481 U.S. at 46; FMC v. Holliday, 498 U.S. 52, 59-60 (1990).

Moreover, where a state statute has been found to affect an integral part of the relationship, the statute has affected the substantive terms of the contractual relationship. See FMC v. Holliday, 498 U.S. at 61 (holding that a state anti-subrogation statute "directly controls the terms of insurance contracts by invalidating any subrogation provisions that they contain"); Metropolitan Life Ins. Co. v. Mass., 471 U.S. at 74 (holding that mandated benefits laws regulate an integral part of the policy relationship "by limiting the type of insurance that an insurer may sell to the policyholder").

The statute in this case regulates the administration of policies, not their substantive terms. As did the Willett panel, we conclude that the Georgia statute does not affect an integral part of the relationship between the insurer and the

insured.[10]

O.C.G.A. §33-24-44(d) does satisfy the third prong of the business of insurance test, since it is aimed solely at entities within the insurance industry. Thus, the statute satisfied only one of the three criteria for deciding whether it regulates insurance. That is not enough to place the statute within the purview of the business

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[10] The plaintiff relies on Gahn v. Allstate Life Ins. Co. to support his argument that the statute affects an integral part of the policy relationship. 926 F. 2d 1449 (5th Cir. 1991). Gahn involved a Louisiana statute that is similar to the statute before us, but is distinguishable. The Louisiana statute at issue in Gahn required written notice for the cancellation of policies, but it also provided that the cancellation would not prejudice benefits accrued prior to the cancellation. Id. at 1455. The latter portion of the statute added substance to the relationship between the insurer and the insured because, as Gahn held, it forbade insurers from discontinuing the payment of benefits to policyholders stricken with terminal illnesses prior to cancellation of their policy. Id. at 1458. Therefore, it mandated the continued payment of benefits after cancellation to certain policy holders. O.C.G A. §33-24-44(d) does not affect the terms of coverage. It regulates the procedure for ending the policy relationship, and adds to the administrative requirements that group policies face.

of insurance.[11]

The Pilot Life opinion indicates a strong preference for preemption of state statutes that concern subjects among the central purposes of ERISA, and indicates that application of the business of insurance test should be informed by the purposes underlying ERISA. 481 U.S. at 51-52. One of the core purposes of ERISA is to provide uniformity in the administration of employee benefit plans and avoid subjecting plan administration to varying standards created by differing state laws. Fort Halifax Packing Co., Inc. v. Coyne, 482 U.S. at 9. Without preemption the Georgia notice provision here and similar statutes and case law in other states would subject the

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[11] Some courts have rules that state statutes failing under the first prong do not satisfy the business of insurance test without even looking to the other criteria. Tingle v. Pacific Mut. Ins. Co. 996 F.2d at 108. We need not address that issue in this case since we readily resolve this case analyzing the statute under all three prongs in light of the core purposes of ERISA.

defendant's Plan, which covers agents of the defendant nationwide, to the varying notice standards of all the states. Such a result would directly conflict with ERISA's goal of establishing a uniform set of regulations for employee benefit plans. The Supreme Court has not hesitated "to apply ERISA's preemption clause to state laws that risk subjecting plan administrators to conflicting state regulations." FMC v. Holliday, 498 U.S. at 59.

Applying the three-pronged business of insurance test in light of the purposes underlying ERISA, we readily conclude, consistent with the Willett panel, that the Georgia notice statute is preempted.[12]

---

[12] We note also that the Plaintiff's tort claim based on O.C.G.A. §33-24-44(d) would clearly be preempted. The second half of Pilot Life added further considerations to the saving clause analysis as it applies to enforcement actions under ERISA plans. 481 U.S. at 52. This next level of analysis considers the saving clause in the context of ERISA's civil enforcement scheme set out in §1132. Section 1132(a) states in relevant part:

A civil action may be brought--

Only the third prong of the business of insurance test is satisfied, and that is clearly not sufficient to save the Georgia statute from preemption. The instant statute relates directly to the administration of insured benefit plans; to permit the saving clause to foreclose preemption would undermine a core purpose of ERISA -- providing uniform standards for

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(1) by a participant or beneficiary--
(A) for the relief provided for in subsection (c) of this section, or
(B) to recover benefits due to him under the terms of the plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan . . . .

The Pilot Life court made clear that §1132 is a comprehensive scheme for enforcement of ERISA plan disputes, adding that "[t]he policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." 481 U.S. at 54. The claim at issue in Pilot Life sought to recover benefits due under the plan pursuant to §1132(a)(1)(B). The instant case concerns a claim that the defendant wrongfully lapsed coverage; thus, it involves a suit to enforce the plaintiff's rights under the plan, which is covered under §1132(a)(1)(B). Therefore, the tort claim would also be preempted. See also, Ingersoll-Rand v. McClendon, 498 U.S. 133, 142-145 (1990).

administration of benefit plans. Accordingly, we hold that the saving clause does not apply to O.C.G.A. §33-24-44(d), and this case must proceed under ERISA.[13]

IV. CONCLUSION

For the foregoing reasons, the judgment of the district court is reversed and the case is remanded for further proceedings not inconsistent with this opinion.

REVERSED and REMANDED.

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[13] Although we express no opinion on the merits of the plaintiff's claims, we note that we have held that courts should review denial of benefit claims under an arbitrary and capricious standard; however, where a conflict of interest exists, that difference diminishes in the manner articulated in Brown v. Blue Cross and Blue Shield of Alabama, Inc., 898 F.2d 1556 (11th Cir. 1990). In the instant case the plaintiff must pursue remedies through the enforcement scheme of ERISA, and any amended claims filed against the plan or other parties arising out of the termination of coverage and subsequent denial of benefits would relate back to the original complaint for purposes of the statute of limitations under Fed.R.Civ.P. 15(c). See Davis v. NMU Pension & Welfare Plan, 810 F. Supp. 532, 537-38 (S.D. N.Y. 1992) (retired union member who brought claim against union could amend claim to sue Plan under the relation back principle).

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

NO. 92-8934

D.C. Docket No. 87-124-COL

CRAWFORD B. SMITH, JR.,
and JEANNIE SMITH,

Plaintiffs-Appellees,

versus

JEFFERSON PILOT LIFE
INSURANCE COMPANY,

Defendant-Appellant.

Appeal from the United States District Court for the Middle District of Georgia

---

Before ANDERSON and CARNES, Circuit Judges, and MERRYDAY*, District Judge.

JUDGMENT

This cause came to be heard on the transcript of the record from the United States District Court for the Middle District of Georgia, and was argued by counsel;

UPON CONSIDERATION WHEREOF, it is now hereby ordered and adjudged by this Court that the order of the said District Court appealed from in this cause be and the same is hereby REVERSED; and that this cause be and the same is hereby REMANDED to said District Court for further proceedings in accordance with the opinion of this Court;

It is further ordered that plaintiffs-appellees pay defendant-appellant the costs on appeal to be taxed by the Clerk of this Court.

---

*Honorable Steven D. Merryday, U. S. District Judge for the Middle District of Florida, sitting by designation.

Entered: February 2, 1994
For the Court: Miguel J. Cortez, Clerk

By: /S/Matt Davidson
Deputy Clerk

ISSUED AS MANDATE: APR 08 1994

IN THE UNITED STATES COURT OF APPEALS

FOR THE ELEVENTH CIRCUIT

No. 92-1166

CRAWFORD S. SMITH, JR., AND
JEANNIE SMITH,

versus

JEFFERSON-PILOT LIFE INSURANCE
COMPANY,

On Petition for Permission to
Appeal an Interlocutory Order
Pursuant to 28 U.S.C. §1292(b)

Before HATCHETT, ANDERSON and DUBINA, Circuit Judges.

B Y T H E C O U R T :

The petition for permission to appeal pursuant to 28 U.S.C. §1292(b) is granted.

The motion of American Council of Life Insurance "ACLI" for leave to file an amicus curiae brief in support of petition for interlocutory appeal is granted.

IN THE UNITED STATES DISTRICT
COURT FOR THE MIDDLE DISTRICT
OF GEORGIA
COLUMBUS DIVISION

CRAWFORD B. SMITH, JR. and JEANNIE SMITH,	*	CIVIL ACTION FILE NO. 87-124-COL
Plaintiffs	*	
vs.	*	
JEFFERSON-PILOT LIFE INSURANCE COMPANY,	*	
Defendant	*	

O R D E R

On April 20, 1992, the Court entered an order in the case above identified sustaining the Plaintiffs' motion for partial summary judgment. Subsequently the Defendant filed a motion for reconsideration of the order. The Court denies the Defendant's motion for reconsideration, but, pursuant to the provisions of 28 U.S.C. §1292(b), amends its order of April 20, 1992, by adding thereto the following paragraph:

It is the opinion of the Court that

this order involves a controlling question of law as to which there is substantial ground for difference of opinion and that an immediate appeal from the order may materially advance the ultimate termination of this litigation.

IT IS SO ORDERED, this 19th day of August, 1992.

/s/J. Robert Elliott
UNITED STATES DISTRICT JUDGE

IN THE UNITED STATES DISTRICT
COURT FOR THE MIDDLE DISTRICT
OF GEORGIA
COLUMBUS DIVISION

CRAWFORD B. SMITH, JR. and JEANNIE SMITH,	*	CIVIL ACTION FILE NO. 87-124-COL
Plaintiffs	*	
vs.	*	
JEFFERSON-PILOT LIFE INSURANCE COMPANY,	*	
Defendant		

MEMORANDUM AND ORDER ON
MOTIONS FOR SUMMARY JUDGMENT

In the case above identified the Defendant has filed a motion for summary judgment and a brief and supplementary matter in support of the motion. The Plaintiffs in turn have filed a motion for partial summary judgment and a brief and supplementary matter in support of their motion.

The Court has given careful consideration to all of the submissions and has concluded that the Defendant's motion

for summary judgment should be denied and that the Plaintiffs' motion for partial summary judgment should be sustained.

In sustaining the Plaintiffs' motion for partial summary judgment the Court determines as a matter of law:

1. That the group health insurance policy provided to Crawford Smith by the Defendant for the coverage of his dependents, wholly paid for by Crawford Smith, is not a "Plan" covered by the Employee Retirement Income Security Act (ERISA).

2. That if it should be thought that the Defendant's insurance coverage at issue did constitute an ERISA Plan the Plaintiffs' causes of action grounded upon the Defendant's violation of the duties imposed by O.C.G.A. §33-24-44(d) survive ERISA preemption because of the application of ERISA's "saving clause".

Accordingly, the Defendant's motion for summary judgment is denied and Plaintiffs' motion for partial summary judgment is sustained.

IT IS SO ORDERED, this 20th day of April, 1992.

/s/J. Robert Elliott
UNITED STATES DISTRICT JUDGE

STATUTES AND REGULATIONS INVOLVED

29 U.S.C. §1132. Civil enforcement

(a) Persons empowered to bring a civil action. A civil action may be brought -

(1) by a participant or beneficiary -

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 409 [29 USC §1109];

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the

plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 105(c) [29 USC §1025(c)];

(5) except as otherwise provided in subsection (b), by the Secretary (A) to enjoin any act or practice which violates any provision of this title, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this title; or

(6) by the Secretary to collect any civil penalty under subsection (c)(2) or (i) or (1).

29 U.S.C. §1144. Other laws

(a) Supersedure; effective date. Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) [29 USC §1003(a)] and not exempt under section 4(b) [29 USC §1003(b)]. This section shall take effect on January 1, 1975.

(b) Construction and application. (1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 4(a) [29 USC §1003(a)], which is not exempt under section 4(b) [29 USC §1003(b)] (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

O.C.G.A. 33-24-44. Cancellation of policies generally.

(a) Except as otherwise provided in this chapter, cancellation of a policy which

by its terms and conditions may be canceled by the insurer or its agent duly authorized by the insurer to effect such cancellation shall be accomplished as prescribed in this Code section.

....

(d) When a policy is canceled for failure of the named insured to discharge when due any of his obligations in connection with the payment of premiums for a policy or any installment of premiums due, whether payable directly to the insurer or indirectly to the agent, or when a policy that has been in effect for less than 60 days is canceled for any reason, the notice requirements of this Code section may be satisfied by delivering or mailing written notice to the named insured and any lienholder, where applicable, at least ten days prior to the effective date of cancellation in lieu of the number of days'

notice otherwise required by this Code section.

29 CFR §2510.3-1(e):

(e) Sales to employees. For purposes of Title I of the Act and this chapter, the terms "employee welfare benefit plan" and "welfare plan" shall not include the sale by an employer to employees of an employer, whether or not at prevailing market prices, of articles or commodities of the kind which the employer offers for sale in the regular course of business.

(2)

Supreme
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No. 93-1735

In The

Supreme Court of the United States

October Term, 1993

CRAWFORD B. SMITH, JR. and JEANNIE SMITH,

Petitioners,

v.

JEFFERSON PILOT LIFE INSURANCE COMPANY,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

BRIEF IN OPPOSITION

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33 pp

QUESTIONS PRESENTED

The "Questions Presented" as stated by Petitioners are not properly presented. The only questions that *could* be presented, and Petitioners have chosen not to directly present them, are the following:

1. Did the Court of Appeals err in the reversal of the District Court, holding that a health plan sponsored by an insurance company for its agents, funded by the employer through an insurance policy that it issued to the Plan; and, including a dependent benefit feature conditioned upon payment of a monthly contribution to the plan, satisfied the prerequisites of ERISA Section 1002(1), qualified as an ERISA-governed welfare plan, and was not removed from ERISA's regulatory design by Plaintiff's interpretation of DOL Regulation 29 C.F.R. § 2510.3-1(e);

2. Did the Court of Appeals err in reversal of the District Court, holding that Petitioners' claim under O.C.G.A. § 33-24-44, as applied to administration of ERISA governed health benefits funded through a policy of insurance, was preempted as a law "relating to" an ERISA health plan; and was not saved from preemption because such law did not qualify as a law which regulates the business of insurance within the "savings clause" of ERISA Section 514(b), 29 U.S.C. § 1144(b).

TABLE OF CONTENTS

Page

QUESTIONS PRESENTED i

TABLE OF AUTHORITIES iv

STATEMENT OF THE CASE 1

STATEMENT OF FACTS 2

REASONS FOR DENYING THE WRIT 5

I. The Court Of Appeals Did Not Depart From Settled Law Or Conflict With Other Courts Of Appeal In Reversing Partial Summary Judgment And Remanding This Cause For Further Proceedings 8

A. The Court Of Appeals Decision Concerning ERISA Preemption Of Petitioners' State Law Claims Is Grounded On Established And Unanimous Authorities; Petitioners' Views Concerning the McCarran-Ferguson Test, As Applied To This ERISA Preemption Question, Are No Basis For Supreme Court Review 9

B. The Court Of Appeals Correctly Held That Petitioners' Tort Claims Are Clearly Preempted; There Is Nothing To Warrant Further Review 15

II. Respondent's Plan Is Governed By ERISA; Exclusionary Regulation 29 C.F.R. § 2510.3-1(e) Does Not Apply. This Circuit Court Correctly So Held; There Is No Basis For Further Review 19

TABLE OF CONTENTS – Continued

Page

A. Petitioners' Refusal To Acknowledge The Distinction Between Acts Of The Employer And Acts Of The Plan Is No Basis For Supreme Court Review 20

B. Under Petitioners' Novel Theory, Insurance Company Sponsored Plans Would Be Removed From ERISA; The Court Of Appeals Properly Rejected Petitioners' Notion. There Is No Basis For Further Review 23

CONCLUSION 25

TABLE OF AUTHORITIES

Page

CASES:

Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 101 S.Ct. 1895, 68 L.Ed.2d 402 (1981) 16

Amato v. Western Union Intern., Inc., 773 F.2d 1402 (2d Cir. 1985) 21

Belasco v. W.K.P. Wilson & Sons, Inc., 833 F.2d 277 (11th Cir. 1987) 17

Dime Coal Co., Inc. v. Combs, 796 F.2d 394 (11th Cir. 1986) 21

Donovan v. Dillingham, 688 F.2d 1367 (11th Cir. 1982) 19, 20, 23

Ed Miniat, Inc. v. Globe Life Ins. Group, Inc., 805 F.2d 732 (7th Cir. 1986), cert. denied, 482 U.S. 915 (1987) 20

FMC Corp. v. Holliday, 498 U.S. 52, 111 S.Ct. 403, 112 L.Ed.2d 356 (1990) 14, 15, 16

Fort Halifax Packing Co., Inc. v. Coyne, 482 U.S. 1, 107 S.Ct. 2211, 961 L.Ed.2d 1 (1987) 14, 16

Gahn v. Allstate Life Ins. Co., 926 F.2d 1449 (5th Cir. 1991) 11, 12, 13, 14

Gelardi v. Pertec Computer Corp., 761 F.2d 1323 (9th Cir. 1985) 21

Graves v. Blue Cross of California, 688 F. Supp. 1405 (N.D. Cal. 1988) 18

Hansen v. Continental Ins. Co., 940 F.2d 971 (5th Cir. 1991) 8, 17

TABLE OF AUTHORITIES – Continued

Page

Ingersoll-Rand v. McClendon, 498 U.S. 133, 111 S.Ct. 478, 112 L.Ed.2d 474 (1990).....6, 8, 15, 17

Kanne v. Connecticut Gen. Life Ins. Co., 867 F.2d 489 (9th Cir. 1988).....9, 18

Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d. 728 (1985) 10, 15

Payonk v. HMW Indus., Inc., 883 F.2d 221 (3d Cir. 1989)..... 20

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987).....6, 8, 10, 14, 16

Ticor Title Ins. Co. v. Federal Trade Commission, 998 F.2d 1129 (3d Cir. 1993) 11, 13

Tingle v. Pacific Mut. Ins. Co., 996 F.2d 105 (5th Cir. 1993) 11

Tomczyk v. Blue Cross and Blue Shield United of Wisconsin, 951 F.2d 771 (7th Cir. 1991)..... 18

Union 2134, UMWA v. Powhatan Fuel, 828 F.2d 710 (11th Cir. 1987)..... 20

Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 102 S.Ct. 3002, 73 L.Ed.2d 647 (1982) 10

Willett v. Blue Cross and Blue Shield of Alabama, 953 F.2d 1335 (11th Cir. 1992)..... 8, 12, 13, 15

STATUTES:

29 U.S.C. §1002.....1, 2

29 U.S.C. §1108..... 24

29 U.S.C. §1132.....7, 8, 16

TABLE OF AUTHORITIES – Continued

Page

29 U.S.C. §1144 ..... 1, 7, 18

McCarran-Ferguson Act 15 U.S.C. §1011 ..... *passim*

O.C.G.A. §33-24-44 ..... *passim*

OTHER AUTHORITIES:

29 C.F.R. §2510.3-1(e) ..... *passim*

STATEMENT OF THE CASE

This Petition, fifty-six (56) pages in length, contains a section titled "summary of facts"; the allegations contained therein are certainly not the "facts" of this record. Petitioners' prolix "fact statement" is composed almost entirely of unproven allegations and argument. Petitioners' self-serving version of events has never been the subject of evidence; there have been no findings of fact in these proceedings. Petitioners' "summary of facts" is nothing but their compendium of allegations which are vigorously disputed.

And, Petitioners' allegations concerning the merits of their wrongful denial of benefits claim are not at all relevant to the instant Petition because, prior to any hearing on the merits of Petitioners' claim, the district court entertained cross-motions for summary judgment on two narrow, strictly legal issues: 1) whether the Company's group medical plan for agents and their eligible dependents (the "Medical Plan" or the "Plan") constituted an "employee welfare benefit plan" within Section 3(1) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §1002(1); and, if the Plan did in fact fall within ERISA's regulatory scope, whether O.C.G.A. §33-24-44, invoked by Petitioners as the basis of their statutory and common law tort claim, is preempted by ERISA Section 514, 29 U.S.C. §1144. The sole relevant

facts of this case, which are of record and undisputed, are as follows.[1]

STATEMENT OF FACTS

At all times relevant, Petitioner Crawford Smith was employed by Jefferson Pilot Life Insurance Company[2] as a sales agent. The Company, in its capacity as employer, provided major medical benefits to agents through a "Group Life and Medical Insurance Plan for Agents and General Agents" (the "Plan"). The Company bore 100% of the costs of Plan medical benefits provided to agents. Petitioners have never contested the fact that the Plan fully satisfied the ERISA Section 3(1) definition of a "welfare benefit plan." 29 U.S.C. §1002(1).

Plan terms were contained in a summary plan description booklet ("SPD") published by the Company.

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[1] Petitioners' protracted "statement of facts" provides little, if any, information probative of the issues before the Court. The Company will not engage in a point-by-point refutation of Plaintiffs' discursive presentation; rather, it returns to governing legal precepts of ERISA application and preemption, which are not affected by Petitioners' self-serving version of "facts".

[2] Prior to 1987, Crawford Smith was employed by Pilot Life Insurance Company. Pilot Life merged with Jefferson Pilot in 1987. Reference to "the Company" or the Company's benefit Plan encompasses Defendant as well as its predecessor, Pilot Life. Petitioners Mr. and Mrs. Smith are referred to by name or collectively as "Petitioners". Respondent Jefferson Pilot Life Insurance Company is referred to as "Respondent" and "the Company". The Company is based in North Carolina and does business in forty-five (45) states. Its agents who participate in the Plan reside in states across the U.S.

The SPD detailed medical benefits and described claim procedures; it included a statement of ERISA rights and remedies. The SPD designated a Welfare Benefits Administration Committee as administrator of the Plan. It informed participants that medical benefits for agents were funded by the Company through group insurance Policy No. 3469 written by the Company to the Plan.

Further, the SPD described the Plan's dependent coverage feature. The Plan provided that eligible dependents could participate in the Plan, and be eligible for medical benefits provided through Policy No. 3469, by enrolling in the Plan and by the agent's payment of monthly contributions on the dependent's behalf. The SPD informed participants that where dependent coverage was elected, the required monthly contributions would be collected via deduction from the agents' commission account. It informed participants that if monthly contributions were not made, then dependent participation in the Plan would terminate. In 1981, Crawford Smith enrolled Mrs. Smith in the Plan under the dependent coverage feature.

In 1986, Plan administrators determined that Mrs. Smith's eligibility for Plan medical benefits was terminated due to Mr. Smith's failure to make the monthly contributions required as a condition precedent to dependent coverage. Mr. and Mrs. Smith disputed the Plan's determination that participation was terminated; they claimed that any failed payment was based on mutual mistake and/or the fault of the Plan and/or the Company. This benefit entitlement dispute became the subject of the instant lawsuit.

In their lawsuit, Petitioners have assiduously avoided making any claim under ERISA and ERISA's Section 502 remedial scheme. Rather, they have made various state law claims including alleged violation of Georgia statute O.C.G.A. §33-24-44, which imposes certain duties concerning notice in the cancellation of insurance policies. Petitioners have argued that this cancellation law governs the Plan, and that O.C.G.A. §33-24-44 notice requirements were not satisfied by Plan administrators when Mrs. Smith's Plan benefit eligibility terminated. Petitioners seek to hold the Company liable for violation of O.C.G.A. §33-24-44 and for tort liability allegedly related to the administrative failure to give notice.

Petitioners have never addressed the fact that the only insurance policy which had any relationship to the subject health benefits, Policy No. 3469, was never cancelled or suspended. There was never a "cancellation" of any policy of insurance within the meaning of O.C.G.A. §33-24-44. The events at issue in this litigation do not involve "cancellation" of any insurance policy; they involve administration of the Plan, and the Plan's termination of Mrs. Smith's eligibility for Plan benefits for failure to satisfy Plan conditions governing dependent coverage.

As noted, prior to any evidentiary hearing, the trial court entertained cross-motions for partial summary judgment on the questions of whether ERISA governed this cause and whether ERISA preempted application of O.C.G.A. §33-24-44 as relating to the administration and termination of the Plan. The district court first rejected ERISA application; and, alternatively held that O.C.G.A.

§33-24-44 as applied to Plan benefit termination, was saved from ERISA preemption as a law which regulates insurance. The Eleventh Circuit granted the Company's petition for interlocutory review of both rulings. After briefing and oral argument, the Eleventh Circuit reversed both holdings of the district court, confirming ERISA plan status and preemption.

The sole issues before the district court, and ultimately before the Eleventh Circuit, were (1) whether the health coverages afforded to Mrs. Smith as Mr. Smith's dependent through the Company Plan, constituted a welfare plan governed by ERISA; and, (2) whether O.C.G.A. §33-24-44, is preempted when applied to the administration of an ERISA governed welfare plan.

REASONS FOR DENYING THE WRIT

Contrary to the Petitioners' claims, this case does not present any conflict with prior decisions of this Court, nor have Petitioners shown that there is a conflict with any decision of another Court of Appeals on the same matter. Petitioners have not substantively identified any conflict, in principle or spirit, with the body of law governing the scope of ERISA preemption and/or the limits of the ERISA savings clause as set forth in Section 514 of the Act. The instant decision, which properly applies McCarran-Ferguson Act, 15 U.S.C. §1011 *et seq.*, indicia to determine whether the cancellation law constitutes a law which regulates the business of insurance, is entirely consistent with this Court's holdings and the decisions of sister Courts of Appeal. Section 514 of ERISA expressly

preempts state laws which "relate to" an employee benefit plan. *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 111 S.Ct. 478, 112 L.Ed.2d 474 (1990); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987). Georgia statute O.C.G.A. §33-24-44, which purports to regulate benefit eligibility and Plan administration, plainly relates to an ERISA plan. The Court of Appeals properly held that such regulation is plainly preempted by ERISA. There is no basis for further review.

The Court of Appeals properly reversed the district court's finding that DOL regulations at 29 C.F.R. §2510.3-1(e) exempt this Plan from ERISA because the dependent coverage provision required a contribution to qualify for health benefits funded by an insurance policy issued by the Company to the Plan. Petitioners concede that there are no conflicting decisions, in principle or otherwise, with the Court of Appeal's interpretation of 29 C.F.R. §2510.3-1(e). There has never been any case which supports Petitioners' novel construction of this Regulation; their strained interpretation would effectively destroy ERISA coverage to all insurance industry employees who are participants in plans funded through policies of insurance issued by the insurer-employer to the plan. Petitioners have grasped at straws to avoid ERISA. There is no basis for this Court's further review.

Contrary to the apocalyptic language and prolix claims asserted in the Petition for Certiorari, the two issues presented to the Eleventh Circuit in this case were narrow and precise. The Court of Appeals reversed the decision of the district court granting partial summary judgment because the district court misconstrued ERISA's

preemption and savings clause, 29 U.S.C. §1144, and misapplied Department of Labor regulations at 29 C.F.R. §2510.3-1(e). The district court failed to consider that the Company health program for agents, funded via a group insurance policy written by the Company to the Plan, was clearly within the definition of an ERISA governed plan; and the dependent coverage feature, which provided coverage conditioned upon a payment to the Plan, would not abrogate ERISA regulation.

The district court further failed to appreciate that Petitioners' claims, although couched in terms of Georgia state law, are in fact grounded on their dispute with Plan administrators concerning benefit eligibility and entitlement. The remedy for alleged wrongful denial of ERISA benefits, which is plainly the crux of this lawsuit, is governed by ERISA's exclusive remedial scheme. 29 U.S.C. §1132. The Court of Appeals correctly so held.

> The *Pilot Life* court made clear that §1132 is a comprehensive scheme for enforcement of ERISA plan disputes, adding that "[t]he policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." 481 U.S. at 54. The claim at issue in *Pilot Life* sought to recover benefits due under the plan pursuant to §1132(a)(1)(B). *The instant case concerns a claim that the defendant wrongfully lapsed coverage; thus, it involves a suit to enforce the plaintiff's rights under the plan, which is covered under §1132(a)(1)(B).*

Appendix, page 31 n.12 (emphasis supplied).

The Court of Appeals held that the health coverages allegedly due to Mrs. Smith were provided pursuant to an ERISA governed health plan. The Court of Appeals confirmed that Petitioners clearly had a remedy for such alleged wrongful denial – the parameters of such remedy was governed by the remedial scheme set forth at ERISA Section 502, 29 U.S.C. §1132.

The arguments set forth in this Petition, like the arguments to the Court of Appeals, reflect Petitioners' efforts to avoid the ERISA remedies which were and continue to be entirely available. The Court of Appeals correctly held that, Petitioners' claims grounded on O.C.G.A. §33-24-44 and state tort law are preempted. The Court properly remanded this cause for further proceedings under the parameters of ERISA.

I. The Court Of Appeals Did Not Depart From Settled Law Or Conflict With Other Courts Of Appeal In Reversing Partial Summary Judgment And Remanding This Cause For Further Proceedings.

The Court of Appeals determination, that O.C.G.A. §33-24-44, and any tort claim thereunder is preempted by ERISA and not saved from preemption as a "law which regulates insurance", is firmly grounded in the language of the statute, and the decisions of this Court, and numerous, unanimous Courts of Appeal decisions. *See, e.g., Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 111 S.Ct. 478, 482, 112 L.Ed.2d 474, 483 (1990); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987); *Willett v. Blue Cross and Blue Shield of Alabama*, 953 F.2d 1335 (11th Cir. 1992); *Hansen v. Continental Ins. Co.*,

940 F.2d 971, 979 (5th Cir. 1991); *Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489, 493-94 (9th Cir. 1988). The instant Petition contains nothing more than a restatement of Petitioners' argument to the Court of Appeals and their insistent disagreement with the Court of Appeals' determination. As shown below, their efforts to identify some "conflict" between the Court of Appeals decision and Supreme Court and/or sister circuit precedents is a distinct failure.

A. The Court Of Appeals Decision Concerning ERISA Preemption Of Petitioners' State Law Claims Is Grounded On Established And Unanimous Authorities; Petitioners' Views Concerning the McCarran-Ferguson Test, As Applied To This ERISA Preemption Question, Are No Basis For Supreme Court Review.

Petitioners' first argument concerns ERISA preemption of O.C.G.A. §33-24-44 as applied to the administration of ERISA governed health benefits funded by insurance. Petitioners argue that the Court of Appeals decision "conflicts with the decisions of at least two other United States Courts of Appeal", and "has misinterpreted the risk-spreading principle as it is generally understood". Petition, pp. 21, 24. Petitioners' arguments misstate the law and provide no basis for Supreme Court review.

The Court of Appeals properly relied on this Court's clear directive that, in construing ERISA's Section 514(b) savings clause, McCarran-Ferguson criteria are utilized to determine whether a state law is directed at the "business of insurance" so as to "escape preemption by operation of

the ERISA savings clause." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985); *see Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. at 41. The crux of Petitioners' disagreement with the Court of Appeals focuses on two McCarran-Ferguson criteria, i.e., the question of whether the subject state law regulates "transfer of risk"; and whether the statute affects an "integral part of the relationship between the insurer and the insured". In fact, the Court of Appeals carefully and correctly considered both of these McCarran-Ferguson criteria in its preemption analysis.

The Court of Appeals' consideration of risk spreading, as applied to O.C.G.A. §33-24-44, was in full accord with this Court's analysis in *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 130, 102 S.Ct. 3002, 73 L.Ed.2d 647 (1982). Citing *Pireno*, the Court of Appeals held that the transfer of risk is completed at the time the contract is entered. Appendix, pp. 24-25. Thus, in full accord with *Pireno*, the apportionment of risk in the instant case (i.e., what medical coverages were to be provided to the group of Plan participants eligible for Plan benefits), was determined at the time that Policy No. 3469 was issued. Neither Mrs. Smith's eligibility for Plan benefits, nor her termination of eligibility, had any effect on the apportionment of risk under this Court's *Pireno* analysis. Petitioners have identified no conflict whatsoever between this Court of Appeals decision and *Pireno*.

On the "transfer of risk" question, the record fact is that Petitioners never purchased and were never issued any policy of insurance by the Company; there was never any risk spread between Petitioners and the Company;

the only policy in question was issued to the Plan. Petitioners' argument, that the "transfer of risk" is governed by O.C.G.A. §33-24-44 (which merely sets notice standards for policy cancellation), was fully argued to and rejected by the Court of Appeals. There is no basis for any further review.

> [A]lthough a statute that prevents cancellation of a policy without notice arguably affects the transfer of risk, since it regulates the conditions under which the insurer must continue to bear risks for the insured, it does not alter the initial apportionment of risk among the parties at the inception of the contract. The first prong of the business of insurance test concerns only laws that impact the original apportionment of risks covered by the policy. The statute before us merely attempts to minimize the risk of noncoverage to persons whose policies lapse. *See, Tingle v. Pacific Mut. Ins. Co.*, 996 F.2d 105, 109 (5th Cir. 1993). . . .

Appendix, p. 25 n.9.

Petitioners cite *Ticor Title Ins. Co. v. Federal Trade Commission*, 998 F.2d 1129, 1134 (3rd Cir. 1993) and *Gahn v. Allstate Life Ins. Co.*, 926 F.2d 1449, 1454 (5th Cir. 1991) and claim that these two decisions conflict with the Eleventh Circuit's "transfer of risk" analysis.

Petitioners simply refuse to appreciate the fact that *Gahn v. Allstate Life Ins. Co.*, 926 F.2d 1449 (5th Cir. 1991) has absolutely no application to the instant facts. The Louisiana statute in *Gahn* which was deemed an insurance regulation for purposes of the ERISA savings clause, is not comparable to O.C.G.A. §33-24-44. The Louisiana

statute does not provide "notice" requirements for cancellation. The Louisiana statute does not deal at all with administrative notice requirements. Rather, the Louisiana statute mandates that medical coverage for certain pre-existing health conditions must continue irrespective of policy cancellation. Here, the Court of Appeals specifically considered and rejected Petitioners' reliance on *Gahn*, correctly noting the substantive difference between the Louisiana mandated insurance benefit law, and O.C.G.A. §33-24-44 administrative notice requirements:

> The Plaintiff relies on *Gahn v. Allstate Life Ins. Co.* to support his argument that the statute affects an integral part of the policy relationship. 926 F.2d 1449 (5th Cir. 1991). . . . [The Louisiana statute] mandated the continued payment of benefits after cancellation to certain policy holders. O.C.G.A. §33-24-44(d) does not affect the terms of coverage. It regulates the procedure for ending the policy relationship, and adds to the administrative requirements that group policies face.

Appendix, p. 28 n.10.

In *Willett v. Blue Cross and Blue Shield of Alabama*, 953 F.2d 1335, 1341 n.6 (11th Cir. 1992) and in the instant decision, the Court of Appeals found that a state statute imposing cancellation notice requirements is administrative; such statute does not qualify as a law which regulates the business of insurance. No "risk is spread" by virtue of a statute which provides a purely administrative notice requirement. The *Willett* decision is conspicuously absent from Petitioners' Brief to this Court.

Petitioners' citation to *Ticor Title Insurance Company v. Federal Trade Commission*, 998 F.2d 1129, 1134 (3d Cir. 1993) adds nothing to their misapplication of *Gahn*, and their contention that the Court of Appeals' analysis of O.C.G.A. §33-24-44 is wrong. *Ticor* does no more than make cursory reference to and reject *Gahn* as inapplicable to the *Ticor* facts.[3] Whatever cursory language the *Ticor* court utilized to summarize *Gahn*, the fact is that *Gahn* dealt with a Louisiana statute mandating continuing insurance coverage as to all existing claims; such is entirely different from O.C.G.A. §33-24-44 which deals only with administrative notice of cancellation; and which is not a law which regulates insurance for purpose of the ERISA savings clause. *Willett*, 935 F.2d at 1341. The Court of Appeals analysis is not in conflict with *Ticor* or *Gahn* or any other Circuit Court decision. There is no basis for this Court's further review.

Petitioners next contend that the Court of Appeals wrongly held that O.C.G.A. §33-24-44 does not impact an integral part of the policy relationship between the

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[3] In fact, the *Ticor* description of the *Gahn* holding is incorrect. In *Ticor*, the Third Circuit described Louisiana state statute at issue in *Gahn*, as "establish[ing] certain conditions precedent to an insurers power to cancel a pre-existing insurance contract". In fact, the Louisiana statute at issue in *Gahn* has nothing to do with "conditions precedent to cancellation"; rather, it effectively prohibits cancellation and mandates continuous coverage as to certain "benefits accrued". 926 F.2d at 1449. Petitioners cannot successfully exploit the *Ticor* misstatement for the proposition that notice/cancellations laws such as O.C.G.A. §33-24-44 must be saved from preemption under the authority of *Gahn*. The Louisiana statute in *Gahn* had nothing to do with "notice of cancellation" that is the subject of O.C.G.A. §33-24-44.

insurer and the insured. The Court of Appeals specifically considered and rejected the Petitioners' continued reliance on *Gahn v. Allstate Life Ins., supra.* The Court of Appeals correctly concluded that a statute which imposes administrative notice requirements incident to cancellation is not comparable to a law mandating benefits. Appendix, p. 28 n.10. Petitioners' citation to the Louisiana statute considered in *Gahn* provides no legitimate support for their claim that O.C.G.A. §33-24-44 must be deemed a law which regulates the "business of insurance". As applied to an insurance funded welfare Plan, such purports to regulate Plan administration, and particularly the administration of ERISA benefit termination. Such state regulation of Plan administration is clearly preempted by ERISA Section 514, and the Court of Appeals correctly so held.

The Court of Appeals correctly analyzed and applied the body of law developed under ERISA which confirms that plan administration is a central ERISA concern; ERISA is designed to provide uniformity in the administration of benefit plans for the protection of all participants. *FMC Corp. v. Holliday,* 498 U.S. 52, 59-60, 111 S.Ct. 403, 112 L.Ed.2d 356 (1990); *Fort Halifax Packing Co., Inc. v. Coyne,* 482 U.S. 1, 9, 107 S.Ct. 2211, 961 L.Ed.2d 1 (1987); *Pilot Life,* 481 U.S. at 46. Uniformity and administrative consistency would be discarded if ERISA plans were subject to administrative cancellation laws of every state in which plan participants reside; rights and obligations would vary according to the state in which the participant happens to live. Such is in stark contrast to this Court's ERISA analysis and the uniform and consistent

administration of welfare plans that ERISA is designed to achieve. *Id.*

The Court of Appeals' holding on preemption fully comports with this Court's directive in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 111 S.Ct. 478, 482, 112 L.Ed.2d 474, 483 (1990), that any doubt regarding ERISA's preemptive force must be resolved in favor of the "breadth" and "deliberately expansive" nature of ERISA's objectives. *See Willett*, 953 F.2d at 1341 n.6. The Court of Appeals, specifically considering the Supreme Court's reasoning in *FMC Corp. v. Holliday*, 498 U.S. at 61 (state anti-subrogation statute "directly controls the terms of insurance contracts by invalidating any subrogation provisions that they contain"); and *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. at 74 (mandated benefits laws regulate an integral part of the policy relationship "by limiting the type of insurance that an insurer may sell to the policyholder"), correctly concluded that the notice requirements of O.C.G.A. §33-24-44 did not satisfy the McCarran-Ferguson criteria and did not regulate "the business of insurance" for purposes of the ERISA savings clause. There is no basis for further review of the Court of Appeals decision.

B. The Court Of Appeals Correctly Held That Petitioners' Tort Claims Are Clearly Preempted; There Is Nothing To Warrant Further Review.

The Court of Appeals held that Petitioners' effort to boot-strap a tort claim to an alleged violation of O.C.G.A. §33-24-44 is clearly preempted by ERISA. Petitioners claim entitlement to Supreme Court review because, in

their opinion, the Court of Appeals' holding is "illogical and fundamentally erroneous." Petition, p.38. Petitioners continue to ignore the overwhelming body of Supreme Court and Circuit Court decisions establishing the exclusive ERISA remedial scheme and confirming preemption of alternative state tort remedies.

The Court of Appeals aptly observed that this Court's decision in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) establishes that, even where the ERISA savings clause would apply, such savings was necessarily limited to the insurance regulation in question. The Court of Appeals confirmed what this Court has made clear; operation of the savings clause must be limited in accord with congressional intent that ERISA provide the exclusive remedy for benefit disputes. Appendix, p. 31 n.12.

Here, Petitioners repeatedly cite *FMC Corp. v. Holliday*, 498 U.S. at 52, for the proposition that "saved" insurance regulations should trigger state law remedies above and beyond the strictly limited ERISA remedial scheme, 29 U.S.C. §1132. The *FMC Corp. v. Holliday* decision contains no such suggestion. Rather, *FMC Corp. v. Holliday* confirms that, in enacting ERISA, Congress' intent was uniformity in the administration of employee benefit plans; elimination of varying standards and remedies created by differing state laws. *Id.*; *see, Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 10, 107 S.Ct. 2211, 96 L.Ed.2d 1, 10 (1987), citing *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 101 S.Ct. 1895, 68 L.Ed.2d 402 (1981) ("We have not hesitated to enforce ERISA's preemptive power where

state law created the prospect that an employer's administrative scheme would be subject to conflicting requirements"). It is settled law that there is no state tort remedy available under the exclusive ERISA remedial scheme.[4]

Petitioners' contention that a state-law tort claim should be available to them, defies the purpose of ERISA, long recognized by the Supreme Court, to preserve a "uniform body of benefit law . . . [and] minimize the administrative and financial burden of complying with conflicting directives among the States . . . [which is] fundamentally at odds with the goal of uniformity that Congress sought to implement." *Ingersoll-Rand Corp. v. McClendon*, 498 U.S. 133, 111 S.Ct. 478, 112 L.Ed.2d 474 (1990). Comporting with such precedent, the Court of Appeals correctly observed:

> The instant statute relates directly to the administration of insured benefit plans; to permit the saving clause to foreclose preemption would undermine a core purpose of ERISA – providing uniform standards for administration of benefit plans. Accordingly, we hold that the savings clause does not apply to O.C.G.A. §33-24-44(d), and this case must proceed under ERISA.

Appendix, pp. 31-32 (footnote omitted).

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[4] *See, e.g. Belasco v. W.K.P. Wilson & Sons, Inc.*, 833 F.2d 277 (11th Cir. 1987) (common law and statutory claims against plan insurer preempted; ERISA preemption extends to insurance coverage disputes); *Hansen v. Continental Ins. Co.*, 940 F.2d 971, 979 (5th Cir. 1991) ("[W]hen beneficiaries seek to recover benefits from a plan covered by ERISA, their exclusive remedy is provided by ERISA").

Petitioners' citation to *Tomczyk v. Blue Cross and Blue Shield United of Wisconsin*, 951 F.2d 771, 776 (7th Cir. 1991) does nothing to support their efforts to avoid this Court's confirmation of ERISA's exclusive remedial scheme. Nothing in *Tomczyk* remotely supports Petitioners' dissatisfaction with the exclusive ERISA remedial scheme. And, the California district court's analysis in *Graves v. Blue Cross of California*, 688 F. Supp. 1405 (N.D. Cal. 1988), concerning an insurance deceptive practice statute, is entirely inapplicable to the instant ERISA benefit eligibility dispute.[5]

The Court of Appeals correctly held that ERISA preemption and the congressional objective of uniformity in ERISA administration, rights and remedies plainly control this O.C.G.A. §33-24-44 claim. The Georgia cancellation statute, as applied to the administration of ERISA health benefits funded by insurance, is preempted by Section 514(a). 29 U.S.C. §1144(a). Petitioners' arguments and the district court's opposite conclusion are contrary to the requirements of the McCarran-Ferguson test, and the weight of authorities here cited. As the Court of Appeals pointedly noted, Petitioners' dispute concerning Mrs. Smith's eligibility for health benefits is governed by the exclusive ERISA remedial scheme; and, Petitioners' ERISA remedy is fully available.

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[5] Moreover, the California district court's rationale is fundamentally at odds with the Ninth Circuit. *Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489, 493-94 (9th Cir. 1988) (ERISA preempts state insurance law claims despite fact that insurance law included private right of action; ERISA's civil enforcement provision is an exclusive remedy).

The Court of Appeals properly remanded this cause to the district court for further proceedings under ERISA's exclusive remedial scheme. This Petition presents no valid basis warranting further review. This Petition should be denied in its entirety.

II. Respondent's Plan Is Governed By ERISA; Exclusionary Regulation 29 C.F.R. §2510.3-1(e) Does Not Apply. This Circuit Court Correctly So Held; There Is No Basis For Further Review.

Applying the ERISA plan criteria of *Donovan v. Dillingham*, 688 F.2d 1367, 1371 (11th Cir. 1982) to undisputed record facts, the Medical Plan is an ERISA-governed welfare arrangement.[6]

Petitioners contend that, despite the fact that the Plan meets the ERISA criteria, the Department of Labor's regulation published at 29 C.F.R. §2510.3-1(e) ("Regulation 3-1(e)") excludes the Medical Plan from ERISA's broad

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[6] In *Donovan v. Dillingham*, 688 F.2d 1367, 1371 (11th Cir. 1982), the Eleventh Circuit identified the criteria to establish an ERISA-governed welfare plan:

> By definition . . . a welfare plan requires (1) a "plan, fund, or program" (2) established or maintained (3) by an employer or by an employee organization or by both, (4) for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, death, unemployment or vacation benefits apprenticeship or other training programs, day care centers, scholarship funds, prepaid legal services or severance benefits (5) to participants or their beneficiaries.

Petitioners have never even attempted to argue that the Company Medical Plan fails the *Donovan* definition of an ERISA-governed welfare plan.

regulatory scope. The Regulation has never been interpreted or applied in the extraordinary manner requested by Petitioners; the Court of Appeals rejected Petitioners' novel approach. There is no conflict with any Supreme Court or Circuit Court decision; there is nothing to warrant Supreme Court review of Petitioners' novel theory to avoid ERISA regulation.

A. Petitioners' Refusal To Acknowledge The Distinction Between Acts Of The Employer And Acts Of The Plan Is No Basis For Supreme Court Review.

Petitioners insist on mischaracterizing the Company's provisions of health benefits through an ERISA welfare plan as a "sale" between employer and employee. Petitioners' theory is in direct contravention of ERISA's recognition of the Plan as a separate legal entity; and, the legal distinction between acts of the employer and acts of the Plan.[7] *See, e.g., Payonk v. HMW Indus., Inc.*, 883 F.2d 221 (3d Cir. 1989); *Union 2134, UMWA v. Powhatan Fuel*, 828 F.2d 710, 714 (11th Cir. 1987); *Ed Miniat, Inc. v. Globe*

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[7] In claiming ERISA exclusion status under Regulation 3-1(e), Petitioners return to their fiction that the Plan dependent coverage option is a separate and independent plan; and required contributions constitute a sale between employer and employee. The fact is that where the employer creates and maintains a medical plan under the *Donovan v. Dillingham*, 688 F.2d 1367, 1371 (11th Cir. 1982) criteria, the ERISA plan status, plan administration ERISA regulation, and preemption, are beneficiaries under plan dependent coverage options. 29 U.S.C. §1002(7, 8). There is no separate "dependent coverage" plan; there is no "sale" of dependent benefits.

Life Ins. Group, Inc., 805 F.2d 732 (7th Cir. 1986), *cert. denied*, 482 U.S. 915 (1987); *Dime Coal Co., Inc. v. Combs*, 796 F.2d 394 (11th Cir. 1986); *Amato v. Western Union Intern., Inc.*, 773 F.2d 1402, 1416-17 (2d Cir. 1985); *Gelardi v. Pertec Computer Corp.*, 761 F.2d 1323, 1325 (9th Cir. 1985).

The uncontrovertible fact, established by the legal identity of the entities involved, is that dependent coverage is not offered for "sale" by the Company. Dependent coverage is offered only by and only through the Plan. The contribution prerequisite to maintain such Plan coverage is not a transaction with the Company; it is a transaction with the Plan. The Court of Appeals correctly held that the contribution that was a requirement of the Plan's dependent coverage feature, did not constitute a "sale" under Regulation 3-1(e) and would not remove the Plan from ERISA's regulatory sweep. There is no justification for further review.

Petitioners offer no case law to support their contention, rejected by the Court of Appeals, that a dependent coverage feature may be severed from the rest of an ERISA plan so as to create a Regulation 3-1(e) ERISA exclusion. The Court of Appeals correctly concluded that ERISA's comprehensive scheme is not escaped by including such a "commonplace feature" of group medical plans. Appendix, p.16. Petitioners' disagreement therewith provides no basis for further review.

The Court of Appeals observed that Regulation 3-1(e) could not remove ERISA regulation merely because an insurer-employer funds a health plan through its own

policy of insurance. Dependent coverage requiring participant contribution is no basis to remove a plan from ERISA's regulatory sweep.

> . . . [Petitioners] argue that Jefferson-Pilot sold the dependent coverage to the plaintiff. Although interpretation of this regulation is an issue of first impression, it is clear that §2510.3-1(e) does not apply to the dependent coverage feature contained in the Plan. The plaintiff seeks to sever the dependent coverage feature from the benefits package provided to agents through the Plan. This cannot be done because the dependent coverage was a feature of the Plan, notwithstanding fact that the costs of such coverage had to be contributed by the employee. The plaintiff offers no case law to support the argument that dependent coverage features may be severed from the rest of an ERISA plan, and common sense compels the conclusion that ERISA regulation is not escaped merely by including such a commonplace feature of group plans. The plain language of the regulation indicates that the regulation contemplates a situation where an individual, who incidentally is an employee of an insurance company, purchases on an individual basis – and not as part of an employee welfare benefit plan – a product from that company. Section 2510.3-1(e) does not apply to situations where an employer-insurer has established an employee benefit plan where both the employee and the employer contribute part of the premium of the plan.

Appendix, pp. 15-17 (footnotes omitted).

The Court of Appeals correctly noted that, if Petitioners had purchased medical insurance through insurance policies issued to them, individually, by the Company, such transaction could constitute a "sale" described in Regulation 3-1(e). Such a "sale" is not at issue in this litigation. Election of a dependent coverage option provided in the context of a welfare plan satisfying the *Donovan v. Dillingham* criteria is not a "sale" between employer and employee.[8] The Court of Appeals correctly concluded that DOL Regulation 3-1(e) has no application; that holding, in conflict with no authority, provides no basis for Supreme Court review. This Petition should be summarily denied.

B. Under Petitioners' Novel Theory, Insurance Company Sponsored Plans Would Be Removed From ERISA; The Court Of Appeals Properly Rejected Petitioners' Notion. There Is No Basis For Further Review.

Petitioners seek to avoid ERISA on the basis that Mr. Smith happened to work for an insurance company. The

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[8] Petitioners for the first time advance the novel argument that Jefferson-Pilot made contributions to the Plan "in consideration of [Crawford Smith's] services" and that, by providing his "services" to the Company, Mr. Smith "paid" for the medical plan coverage. Petition, pp. 52-53. The contention is patently absurd. Employers do not "sell" employee benefits; employees do not "buy" them by working. Petitioners' latest attempt to avoid ERISA must fail.

In any event, the argument is raised for the first time in the Petition; neither the district court nor the Eleventh Circuit had this proposition before them. This Court can reject the eleventh-hour argument as waived.

crux of Petitioner's ERISA-exclusionary argument is that employee-paid dependent coverage under an insured plan is exempt from ERISA if the employer-insurer writes the policy funding its employee benefits, and any type of employee contribution is required. Petitioners' argument, taken to its logical conclusion, would void ERISA protections for all participants of the Medical Plan; and for untold numbers of insurance industry employees and their families participating in similar plans. The U.S. insurance industry employees are estimated by the Department of Labor to exceed two million people.

If Petitioners' ERISA exclusionary theory was accepted, two million households could be deprived of ERISA protection merely because benefits are funded by insurer-employers through their own policies and, for some portion of coverage, an employee contribution is required. As the Court of Appeals observed, the use of an insurance policy to fund benefits and the requirement of an employee contribution are both fully authorized by ERISA. The Petitioners' effort to avoid ERISA based on Regulation 3-1(e) was properly rejected.

> Congress expressly contemplated the use of insurance to fund ERISA benefits since it defined covered programs as those funded "through the purchase of insurance or otherwise." 29 U.S.C. §1002(1). Furthermore, ERISA expressly permits insurer-employers to use their own insurance policies to fund ERISA governed benefits by exempting such transactions from the statute's prohibited transaction provisions. 29 U.S.C. §1108(b)(5). Thus, Jefferson-Pilot's issuance of its own policy to fund the Plan does not defeat ERISA coverage. The Secretary of

> Labor has also expressly acknowledged ERISA jurisdiction over plans that deduct employee contributions. 29 C.F.R. §2510.3-102.

Appendix, p. 17 n.4.

Under the Petitioners' theory, ERISA protections would be denied to insurance industry employees and their families. There is no rationale or justification for such an arbitrary and far reaching result. The Court of Appeals held, properly, that Regulation 3-1(e) has no application to these facts; ERISA coverage is not abrogated based on the industry of the employer. This Petition contains no facts or law to warrant further review of this issue.

CONCLUSION

This lawsuit is grounded on alleged wrongful denial of health benefits provided, sponsored and partially funded by Crawford Smith's employer, through a group Plan. The Court of Appeals correctly held that the Plan and the benefit entitlement dispute which are the crux of this claim, are governed by ERISA.

The Court of Appeals correctly refused Petitioners' contention that the Georgia insurance cancellation statute, which governs the administrative steps necessary for cancellation of an insurance policy, is saved from ERISA preemption through Section 514(a), as applied to the administration of ERISA governed health benefits funded through insurance. The Court of Appeals correctly and carefully applied the McCarran-Ferguson criteria to conclude that the cancellation statute did not qualify as a

state law regulating the business of insurance; and therefore was not saved from preemption as a state law regulating insurance. The Court of Appeals further correctly held that a litigant may not boot-strap a tort claim to an O.C.G.A. §33-24-44 claim to avoid ERISA's exclusive remedial scheme.

And, the Court of Appeals correctly rejected Petitioners' misapplication of 29 C.F.R. §2510.3-1(e), and correctly refused to eliminate ERISA regulation as applied to insurer sponsored and funded plans.

This case simply does not present any issue which is appropriate for consideration by this Court on certiorari. The rulings below involve narrow legal questions which were fully addressed by the Court of Appeals, involve no significant conflict of circuit court decisions, and were resolved by the Eleventh Circuit in full accord with the body of Supreme Court and circuit court precedent. The Court of Appeals fully identified and confirmed Petitioners' ERISA remedy. The Court of Appeals properly remanded this cause for trial on the merits under ERISA's exclusive remedial scheme. Petitioners' continued dissatisfaction with that federal remedy provides absolutely no basis for Supreme Court review. This Petition for Certiorari should be denied.

Respectfully submitted,

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Dated: June 30, 1994